National MyMedicare PHN Implementation Program

phn COOPERATIVE
An Australian Government Initiative

phn GOLD COAST
An Australian Government Initiative

Models of Primary Care

In Residential Aged Care Homes (RACHs)

Acknowledgement

This document has been developed by PHN's nationally through the National MyMedicare PHN Implementation Program. We acknowledge that some resources used or referenced within this document are from organisations including the Department of Health, Disability and Ageing, Services Australia and Royal Australian College of General Practitioners (RACGP). These organisations retain copyright over their original work. Referencing of material is provided throughout.

Disclaimer and Recognition

While the Australian Government Department of Health, Disability and Ageing, has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed, by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage arising from the use of or reliance on the information provided herein.

The information in this document does not constitute clinical, business or legal advice and the PHN Cooperative accepts no responsibility for the way in which information in this document is interpreted or used.

Due to constant developments in research and policy, the information in this document will need to be updated regularly. Please contact the PHN Cooperative if you have any feedback regarding the content of this document. Just wondered if it should be us as the national team, not the cooperative for feedback.

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

Contents

Click on the relevant section heading to navigate to the section you would like to read.

Section 1 – Introduction

Recommendation 56; A new primary care model to improve access from The Royal Commission into Aged Care Quality and Safety final report (2021), proposed the development of a new model of primary care to 'encourage the provision of holistic, coordinated and proactive health care for the growing complexity of the needs of people receiving aged care.' The future-fit primary care model in residential aged care encompasses strengthened relationships between the resident and their General Practitioner (GP), inter-operable information systems supporting information exchange and enhanced multidisciplinary teamwork offering proactive care – all of which are known enablers of quality care.

Provision of timely, quality and consistent primary care for residents in aged care is critical to their wellbeing, quality of life and to reducing preventable hospital admissions (1). Securing robust and reliable models of general practice care delivery is a challenge for many Residential Aged Care Homes (RACHs) in Australia. It is known that the peak periods for clinical care for residents are likely to be at the time of entry to the RACH and during end-of-life palliative care (2). Further, there is an emerging trend in Australia of people entering RACH care with higher acuity needs, are closer to end-of-life (3) and a significant number of residents die within 6 months of entry (4).

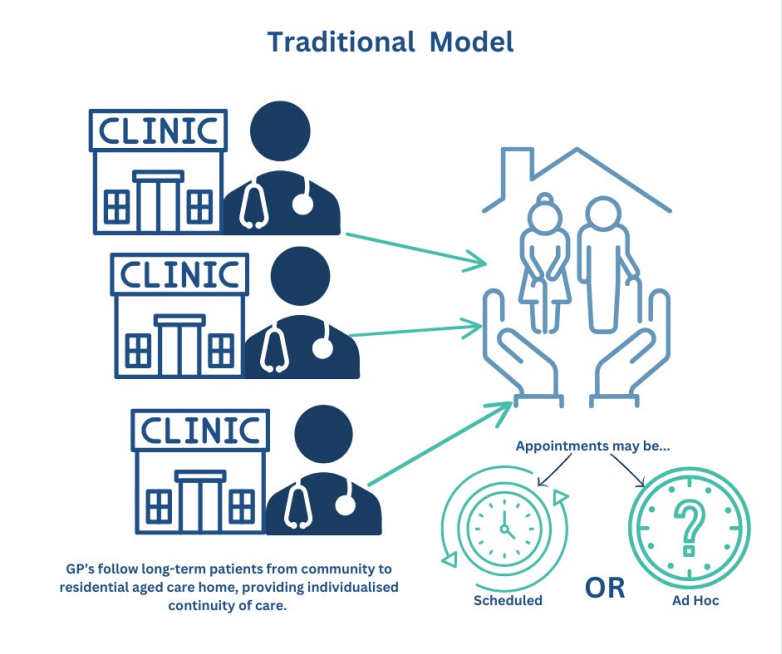
The primary care and aged care sectors are undergoing significant reforms. Consistent with a vision to deliver high quality person-centred care for older people where and when they need it, this document provides an overview of known and emerging models of primary care in RACHs. Drawn from literature, this compilation outlines characteristics for a range of primary care service delivery and business models. It is envisaged that this information will be useful to PHN staff in supporting general practices and aged care providers who are considering improvements in models of care.

This document was developed through a review of published literature and other documents, reports and industry publications on relevant models of care. Identified models of care were discussed by a working group to compare the models described (based on experience), and to explore enablers and opportunities for contemporary investment. This process has identified a gap in available literature describing different models of care and the outcomes that they deliver. Further work is encouraged to develop an evidence base regarding the effectiveness of various models of primary care for RACH residents.

Section 2 – Service Model Profiles

There are varying models by which primary care services are delivered within RACHs. These are described as operational service models, with characteristics of each model outlined below.

The purpose of this section is to highlight the diversity of models, with an aim to broaden awareness of barriers and enablers inherent in each model. Note that models are not mutually exclusive; in practice, a RACH setting may have multiple models operating within their service.

Service Model	Details
Traditional Model 	**Description** Traditional service models see individual residents cared by their chosen GP. GPs visit RACHs on a routine or ad-hoc basis as clinically relevant. This likely involves multiple GPs visiting the RACH. A GP may have cared for their patient in the community and then continues as the primary GP when the patient enters residential care. This model is also termed the continuity model in certain literature (1). **Model Characteristics** • GP-Patient continuity from community to RACH • Care is responsive and episodic • Multiple GPs service the same RACH, potentially without a regular schedule. • GP availability is variable, may be planned or unpredictable. • Challenges in managing chronic conditions and preventative care due to episodic nature of visits. • Modality may be virtual and face to face.
Considerations • Challenges of this model include securing regular and consistent after-hours access and having rapid access to care in acute circumstances.	**Enablers** • Adequate GP numbers in broader community settings. • Established systems for information sharing, joint care and scheduling.
Opportunities • Promotes dignity of choice for residents and continuity of care in instances where residents have retained the same GP.	

Considerations	Enablers	Opportunities
• Coordination of GP access may be difficult for RACHs with high volumes of GP providers. • Variation in specialist skills such as palliative care and dementia care. • GP capacity can be impacted with multiple patients residing across homes (5).	• Maintenance of long-term provider-patient relationships (1). • Better knowledge of patient existing from previous health care relationship (1). • This model is seen as the preferred model by the RACGP, with the view that it is generally best for elderly patients to continue to see their regular GP.	• This model can both enhance planned care, as well as minimise planned care, pending the regularity of visits by the GP. • Provides for an ongoing connection to the community that residents in RACH settings seek.

Traditional Model Example:

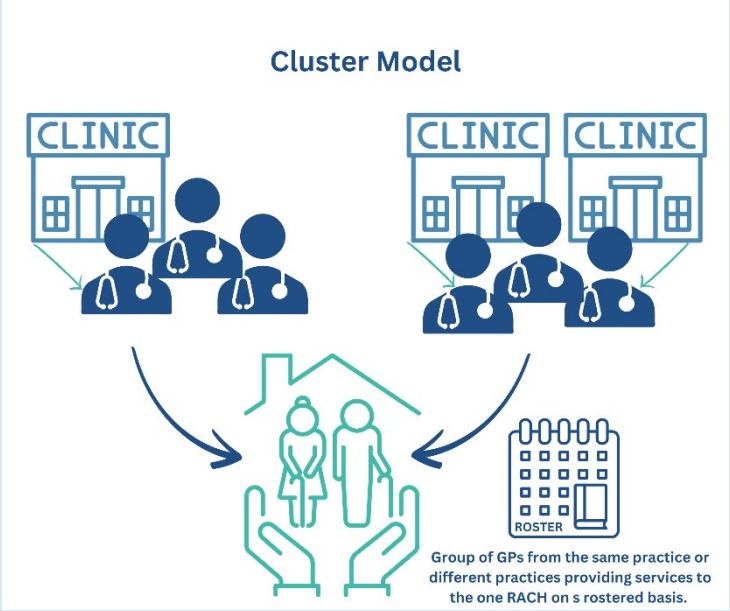
Mrs Jones recently moved to an aged care home nearby.

Her long-term family GP, Dr Brown, agreed to continue providing primary care services to Mrs Jones at the aged care home.

Dr Brown has two other patients at the same location but does not routinely take on the care of residents living in aged care homes. Dr Brown states that he is happy to continue to care for his existing patients when they transfer to a RACH. Dr Brown schedules his visits to the local RACH in and around his practice commitments and uses a deputising GP service for out of hours cover.

Service Model	Details

Cluster Model



Description

The cluster model involves a consistent group of GPs or practices who provide care to all residents in the RACH on a roster system.

In some texts this is referred to as a panel model (1).

Model Characteristics

- Routine and planned patient visits in accordance with a roster.
- Multiple, regular GPs make up the visiting workforce.
- Potential for enhanced access to GPs and visits for residents.
- Modality of delivery includes virtual and face to face.

Considerations

- If the cluster model is the sole model available in the RACH, resident choice for their care provider is limited. Resident choice needs to be balanced and supported.
- Administrative requirements require coordination and leadership – someone to draft, manage and share the roster.

Enablers

- Proximity of RACH to general practices results in greater willingness of GPs to commit and have capacity to visit the RACH.
- Formalised service delivery agreements assist to define parameters and expectations of providers.

Opportunities

- A team approach to caring for patients within the same RACH may see less burden placed on one practitioner and enhance care access/sustainability.

Cluster Model Example:

A large regional town has 3 General Practices who care for the community.

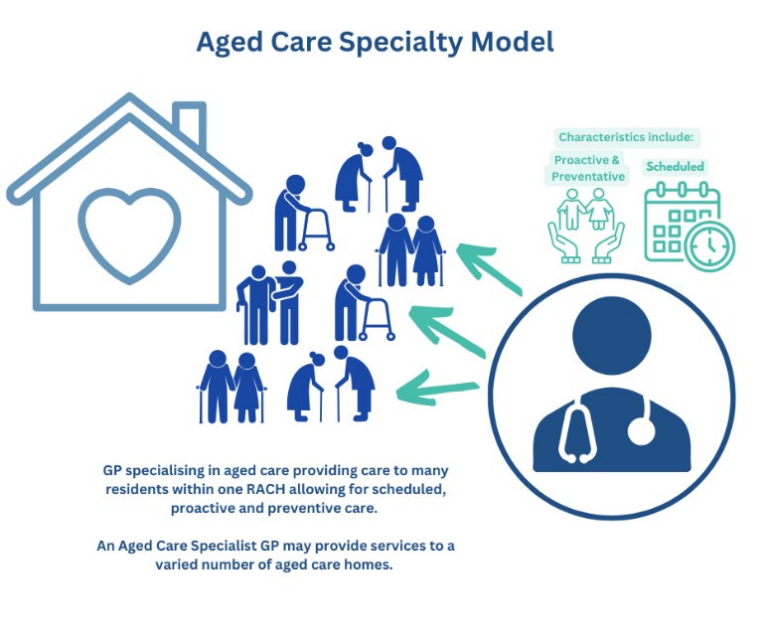
Across the 3 practices, 8 individual GPs have agreed to deliver care to patients in the RACH. A practice manager from one of the practices takes responsibility for drafting the roster on a quarterly basis and shares it with the RACH. The roster nominates two GPs per week to visit the RACH, with scheduled visit times. The roster also nominates an on-call after hours GP.

The GPs find value in the model where they know their patients are cared for by their peers, and they also can call upon medical coverage during periods of leave. Over time, each GP becomes familiar with all 50 patients residing at the RACH.

The RACH is satisfied that the model delivers reliability and consistency for them, specifically, they know which GP is scheduled to visit and when. The RACH can prepare the patients ahead of time and can brief the GP when the GP arrives. The RACH feels comfort in this model with routine access to primary care.

Service Model	Details

Aged Care Specialty Model



Description

This model engages GPs who specialise in aged care or solely practice within RACHs.

A specialised GP or service of GPs assumes responsibility for providing care to all residents in the RACH. Aged Care Medical Homes are an example of this. Sometimes these models are exclusive and preclude residents from engaging their own GP for their care needs.

The service may support multiple RACHs and may or may not operate from a typical bricks and mortar general practice (e.g. a mobile service).

Model Characteristics

- GPs with a special interest in aged care or a specialty service delivers care to RACHs.
- Clinicians may offer aged care clinical specialties/expertise and facilitate proactive management of chronic conditions, preventative care, treatment for dementia and end of life care.
- Enhanced continuity of care and familiarity with residents' health needs.
- Regular face to face delivery supplemented by virtual care access.

Considerations

- GPs with a special interest in aged care are likely to be fewer in number but may provide care for high volumes of RACH patients. This gives rise to risk of burnout, workforce sustainability and vulnerability for succession planning in times of sickness, leave or service cessation.
- Accessing and sustaining after-hours care support.

Enablers

- Established after-hours protocols.
- Established networks of GPs who operate similar models, allowing for coverage during periods of leave.
- Incentives supporting care delivery in RACHs and underpinning business models.
- Geographical locations and availability of training to support aged care specialty skill growth.

Opportunities

- Development of specialised interest and advanced skills.
- Business growth opportunities through specialised aged care support.
- Evaluation of whether the exclusive nature of this model provides increased care access without competing demands of a day-time general practice.
- Evaluation of whether the model results in improved care experience.

Aged Care Specialty Model – Individual Practitioner Example:

Dr Adams is a sole practicing GP without a physical practice location (i.e. operating a mobile service) and delivers care exclusively in RACHs. She comprises a case load of 200 RACH patients across 4 RACHs and schedules weekly visits to each RACH.

The RACH staff are aware when she is due to visit and ensures residents are ready to be seen when she arrives. Outside of scheduled visits, Dr Adams responds to acute patient needs (either via telehealth or face to face) when the RACH calls.

Dr Adams has 3 GP colleagues who similarly practise as sole GPs providing primary care for RACH patients. The four GPs provide cover for each other on a roster basis for after-hours support and during holidays.

Dr Adams has fostered an interest in caring for the aging adult and has extended her professional expertise in this area as a specialty, she is known well in the local area for her extensive experience caring for patients with dementia.

Aged Care Specialty Model – Group Arrangement Example:

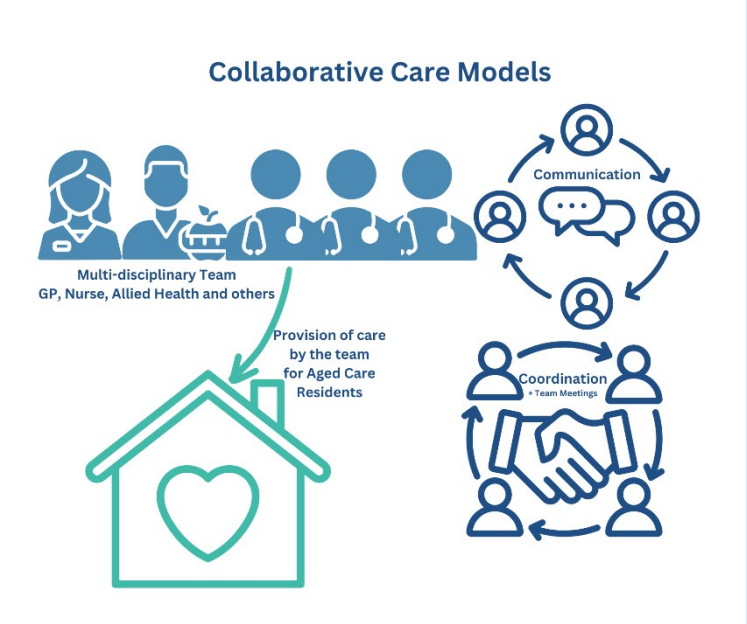
South Coast Aged Care is a small business that contracts 9 GPs (equating to 6 full time equivalent GPs). Currently, the business has agreements with 6 RACHs to care for all residents residing within these homes, both within and outside of business hours. All 6 RACHs are within a 50km radius of the primary registered business location.

The GPs working for this business consider themselves as GPs with a special interest in aged care. Administration and billing support is provided by staff from the business.

The GPs pay 30% of their MBS billings to the business. The GPs are provided with laptops and access to clinical software.

Service Model	Details

Collaborative Care Model



Description

The collaborative care model is a team-based model with care coordinated by the GP. This model integrates care between the GP, RACH nurses, Practice nurses, allied health professionals, and specialists within the RACH, fostering a team-based approach.

Practice nurses may support care as delegated by a GP (1). This model is also termed the Longitudinal Practice Model in some texts (1).

Model Characteristics

- Greater involvement of consistent allied health, specialist providers and primary care providers (as an extension of cluster model with greater multidisciplinary team involvement).
- Enhanced access to and care delivery from multidisciplinary team enables continuity of care with regular communication.
- Routine team meetings and case conferences help to coordinate care plans and care planning.
- Potential for improved management of patients with chronic conditions, complex care or high care needs or deterioration.
- Modality may be offered via virtual and face to face.
- Can include Nurse Practitioners providing primary care services as part of the team-based model.

Considerations

- Funding models for practice nurses, nurse practitioners and allied health to provide primary care in the RACH setting are limited.

Enablers

- Highly trained and capable nursing staff to facilitate case conferencing, clinical coordination and care planning.
- Aboriginal Health Practitioner workforce to complement care team and support coordinated care.

Opportunities

- Patients may experience increased access to primary care (6).
- Utilisation of the General Practice in Aged Care Incentive as it promotes the integration of the broader primary care team in the delivery of primary care services for patients in RACH settings.

Considerations	Enablers	Opportunities
• Capacity of and access to multidisciplinary providers in areas of workforce shortages, particularly in regional and rural areas.	• Established after-hours protocols. • Sufficient workforce access and supply. • Clinician experience in team-based care delivery are known to increase work satisfaction and drive retention rates.	• Opportunities for general practices to partner with independent nurse practitioners to assist in providing primary care services in RACHs as part of the team-based model (1). • Example in practice: General Practice in Aged Care Incentive and the MBS allows for payments for nurse practitioner services in RACHs if engaged in collaborative practice with a general practitioner. Multidisciplinary teams can also be optimised for care support.

Collaborative Care Model Example: Solo Practice

The Bluey General Practice Group is a large primary care practice in an urban city in Australia. This General Practice employs over 40 general practitioners, 20 practice nurses and 4 nurse practitioners. The practice also has allied health professionals who practice from the site including specialists in physiotherapy, dietetics, exercise physiology, speech therapy, social work and psychology.

The practice is growing its interest in supporting residents within RACHs and sees opportunity to streamline their model. The practice has responsibility for exclusive care provision for three RACHs. A team to support this has been established with 4 GPs, two practice nurses, a nurse practitioner, a fraction of each allied health team member time, and a dedicated admin team member at 0.5 FTE.

The team hold weekly team coordination meetings, and once a month case conferencing with families and residents. The multidisciplinary approach is advantageous as this patient cohort have access to allied health from within the same care team.

Collaborative Care Model Example: Cluster Practice

A cluster of GPs on a roster system have supported the same 4 RACHs for the past 3 years. Over this time, the GPs have worked hard to build relationships with the array of allied health staff that are employed and contracted by the 4 RACHs. There are different staff in each RACH and varying disciplines also.

The GP cluster have developed an approach they apply consistently to encourage collaboration. This involves a 2 hour teleconference each month per RACH with the entire multidisciplinary team, whereby care plans are reviewed and progress is discussed.

Outside of this, the clinicians communicate through the messaging system provided by the RACH. Each clinician maintains responsibility for their own notes in their own software and summaries are shared to the patient's My Health Record.

Service Model	Details

RACH-Led Care Model

Description

RACH-led models employ or contract GPs/primary care services to care for all residents. The GP is integrated as part of the care team. Care is delivered 'clinic-style' and may involve a proxy general practice on site.

Model Characteristics

- GP may be co-located within the RACH.
- Primary care is responsive and integrated.
- Offers aged care specialty support.
- GP employment/contract model is led by the RACH.
- The RACH designates a clinical coordinator to assist the GP.
- Business model may see GPs salaried and Medicare subsidies are returned to the RACH or may see a partnership between a practice and a RACH.

Considerations

- Additional burden of compliance on RACH provider to operate a GP service.
- Difficulties in RACHs employing GPs directly and reaching agreement on a business model that is acceptable to both parties.

Enablers

- Clinical coordinator to support the GP and streamline care.
- Ratio of one GP per 150 residents in a facility.
- As this model is RACH- led, GPs are often encouraged to have input into processes for clinical governance at the RACH, enhancing collaboration, quality & safety.
- Long history of RACHs in the United States (US) partnering in this style with GPs. The US mandates the involvement of GPs in clinical governance within a RACH – therefore there is strong evidence of this model from the US (1).

Opportunities

- There is an emerging need for designated business models specialising in aged care. These models promote regular, sustainable care for residents in RACHs.
- Co-located/onsite models promote rapid access to care for residents with acute care needs or who are deteriorating.
- Example in practice: BUPA Aged Care ran a trial employing GPs to work in its facilities in line with this model of care, (1). During the BUPA trial, 4 of the 15 sites were unable to employ a GP and a further 4 had inadequate GP coverage (7) (11).

RACH Led Model Example:

A mid-size corporate aged care provider, Daisy Aged Care, operates 10 RACHs.

This area is a known thin market for GPs and the managers of Daisy Aged Care are willing to consider innovative approaches to ensuring their residents have access to primary care.

The 10 sites operated by this RACH provider have recently been built and have onsite GP clinical rooms built within or adjacent to the RACH.

The provider contracts 5 GPs to work across the 10 sites. The GPs work from 2 RACHs each utilising MBS payments for episodic and comprehensive care for residents. The model delivers bedside care to those with mobility issues as well as in the co-located clinics. A well panned schedule ensures appropriate medical coverage within and outside of business hours.

The GPs develop a relationship with all care staff, nursing staff and allied health providers. They are seen as an integrated member of the team, and conduct regular case conferencing, facilitating coordinated care. In addition, they grow a strong working knowledge of the RACH requirements for clinical and corporate governance procedures.

Service Model	Details

Specialist In-Reach Models

Description

This model facilitates in-reaching speciality services for specialised care and sometimes primary care in the absence of regular GPs or in a workforce shortage. Specialty care may enable triage and escalation, palliation, specialised psychological or dementia support. Virtual, telemedicine and remote consultations may be frequent. Contracts can exist directly between the RACH and the specialty service.

Model Characteristics

- Telehealth modalities may be frequent in conjunction with site-based nurse.
- The specialist model described was seen as complementary to more traditional face-to-face GP or nurse visits to RACHs (8).
- May occur more frequently in the absence of GPs and/or as a solution for hospital avoidance.

Considerations

- Costs of specialist services are usually higher compared to GP services (8).
- Infrastructure requirements for remote service access.
- Care continuity may be reduced if not coordinated with usual GP (8).
- This model is more effective in combination with a model supporting usual/routine GP care e.g. for managing acute or deteriorating conditions rather than ongoing care.

Enablers

- Improved RACH staff capability and development through working with diverse specialities.
- This model is effective when face to face care is unavailable, and access to regular local care is poor.
- Providing specialist in-reach into RACHs, particularly after-hours, improves access to care for patients in RACHs when fewer medical practitioners are available (8).

Opportunities

- Solution to workforce shortages can include models such as specialist in-reach, sometimes with one provider contracted across multiple RACHs. Pathways for escalation to hospital and local services can be replicated.
- Example in practice: The MED service, commissioned by one PHN for care delivery to 6 RACHs, was found to improve access to timely after-hours services in the absence of other care services.

Specialist In-reach Model Example:

Tulip Aged Care is a residential aged care home in a regional town. There is one general practice in the town, who do not have capacity to provide primary care services at the RACH.

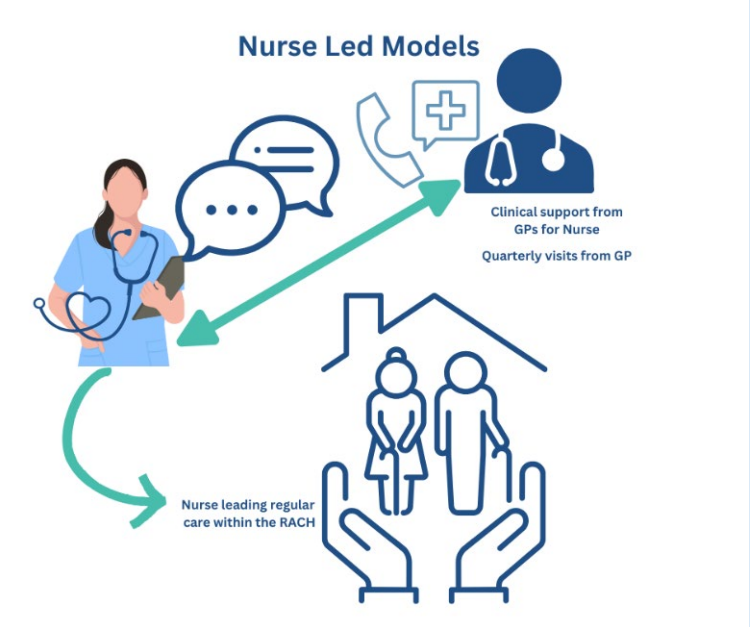
In-reach Direct Primary Care is a specialist care service that provides telehealth. The organisation is located in the nearest capital city to this regional town; 2.5 hours' drive away. They work together with RACHs to deliver care, mostly via telehealth, with quarterly onsite visits.

The service has now employed 30 general practitioners who work varying hours supporting care to RACHs as well as tele-health triage. GPs are assigned to a RACH to foster continuity of the doctor-patient relationship. Services are a maximum distance of 3 hours from the GPs location. Most GPs work from their home location, with some working from the corporate office.

This service ensures that RACHs can access both ongoing general practice care as well as emergent, episodic care when needed. The organisation, having a pool of 30 GPs, also offers appropriate coverage for after-hours care.

Service Model	Details

Nurse Led Models



Description

Nurse Practitioner (NP) led care, delivering on-site primary care needs, or specialist services, with support from GPs, enabling increased access and elevated clinical support.

Model Characteristics

- A nurse practitioner led model in partnership with a GP to provide primary care services.
- This may also be a nurse-led service to provide sub-speciality care services for patients in RACHs (e.g. palliative care). Often provided by Clinical Nurse Consultant qualified nurses with a sub-specialty (5).

Considerations

- Limited funding sources for nurse compensation and thus may require seed funding, may impair sustainability.
- Workforce limitations (number and distribution of NPs available).
- Clarity of roles and responsibilities NPs and clinical staff, including GPs (9).
- Policies and procedures are required when integrating and introducing a new discipline with the care team (10).
- Limited understanding of new and emergent roles and associated scope of practice can limit uptake of the service (9).

Enablers

- Enables improved clinical capacity within the RACH and facilitates timely care (e.g., nurse practitioner support in lieu of GP (5)).
- Integrated notes with GP clinical software.
- This model provides for efficient collaboration, enhanced assessment and surveillance of older people. Studies have demonstrated improved communication with GPs and local hospital emergency staff, and improved support for RACH staff due to an onsite NP (10).

Opportunities

- NPs add a vital role within a primary care team, they are highly skilled in assessment and intervention of the acutely unwell older adult, while offering other complimentary skills sets and autonomous practice, (10).
- Appendix 1 identifies the MBS items available for NPs in Australia.
- Example: Care in Modern Age Services (CiMaS) is a nurse-led company providing aged and palliative care in both community and RACHs settings in Queensland (5). The service has been commissioned by PHNs to support specialised nursing care for RACHs.

Nurse-Led Model Examples:

Purple Sphere Health Care is a nurse-led primary care service, in a small rural area that has some difficulty recruiting long term GPs. The practice is auspiced by a larger accredited general practice 100km away.

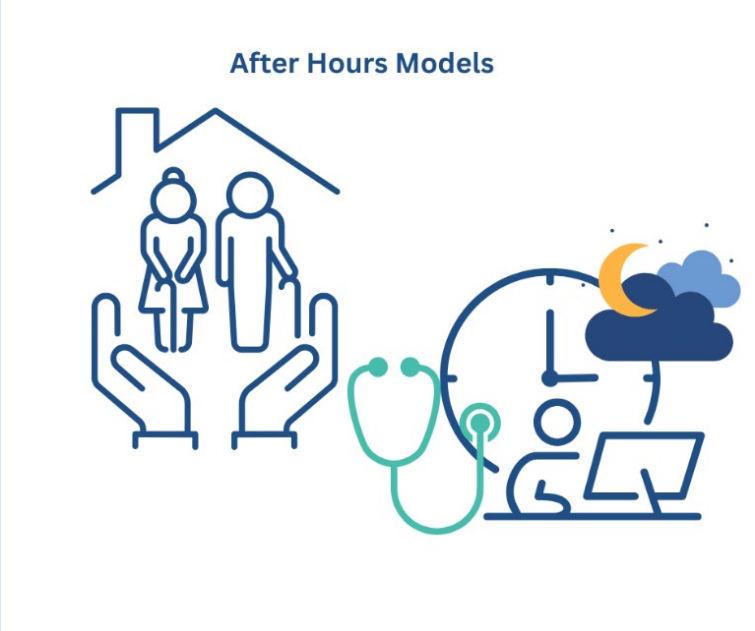
The practices support the local 30 bed RACH near to Purple Sphere. The nurse led service employs one NP and 3 practice nurses, as well as one full time and one part time admin, the full-time admin team member acts as the practice manager.

One week per month a general practitioner from the governing practice attends. These visits provide important clinical governance support for the nurse-led clinic.

The NP oversees the care for residents in the aged care home, with remote monitoring assistance from GPs in the governing practice. The NP offers a high degree of skill in wound care, dementia care and chronic condition management.

Service Model	Details

After Hours Models



Description

All RACHs require access to after-hours care. Options for afterhours models include:

- Arrangements with deputising services.
- Arrangements as an extension of in-hours model.
- RACH fast track models as partnerships with local hospitals.

Model Characteristics

Ability to secure after hours care for residents with clinical support for escalation and triage.

Considerations

- Independent after-hours services lack familiarity with residents as compared to GPs (12).
- GPs may be less willing to provide after-hours care in a RACH due to risk, capacity and fear of burden (e.g. receiving frequent calls about minor issues (8)).
- After hours care is needed for acute needs rather than chronic conditions or when procedural intervention is required (8).

Enablers

- Having a deputising service to relieve usual GPs from round the clock care can help attract GPs to work in RACHs (8). GPs can provide handover information/ instructions for a deputising service to ensure continuity of care.
- Deputising services offer reliability of care to residents after hours.

Opportunities

- Emerging models of higher acuity after-hours care provision are occurring in response to hospital avoidance plans and partnerships with health & hospital networks/districts.
- Further, clusters of RACHs in close proximity to each other may benefit from shared or contracted models.
- In NSW, My Emergency Doctor (MED) telehealth service provides afterhours consultations to a cluster of 6 RACHs. MED doctors are accredited Emergency Medicine Specialists; this is a fee for service organisation (8).

After Hours Model Example:

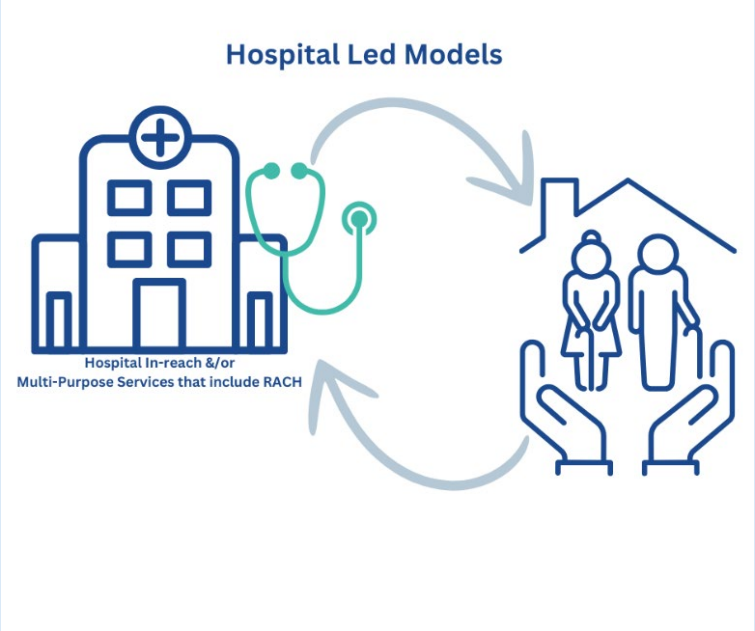
Health On Call is a telehealth and care service that provides medical deputising services to residential aged care.

While it is usually better for residents in aged care homes to be seen by their regular GP, at times, during after-hours or when the usual GP may be away, Health On Call provides afterhours coverage for RACHs.

This service provides support to General Practitioners and their patients in Residential Aged Care Homes and ensures continuity of care and appropriate clinical handover through rapid communication. The practice and RACH subscribe to this service as the nominated medical deputising service. The general practitioners who provide the regular care to the residents receive clinical notes following the care episode and a summary is uploaded to My Health Record.

Service Model	Details

Hospital Led Models/ Multi-Purpose Services



Description

Multipurpose service (MPS) models foster partnerships with local hospitals for operational support and management of residential aged care beds. Similarly, hospital-led models enable in-reach for higher acuity care needs, for hospital avoidance.

Model Characteristics

- Funded beds within RACHs/hospitals for residents requiring higher acute care or models where the hospital auspices the RACH (in full or part), with funding and staffing.
- Service integration optimises workforce for rural and remote communities.
- In reach secondary care to treat patients with acute needs.
- Hospital led programs may focus on hospital avoidance and managing patient deterioration.

Considerations

- Diversity in service models between State & Territory jurisdictions.
- Workforce availability in rural and remote regions.
- Balancing clinical and residential infrastructure requirements (i.e. offering a clinical hospital environment with residential comforts of a RACH).
- Diversity in acuity needs of residents for sub-acute services verse comprehensive primary care (1).

Enablers

- Positive partnerships with local hospitals.
- Reduced transfer to hospital for residents.
- Greater access to specialty care and identification of early deterioration.
- Opportunities for workforce development and specialty skill development.

These models have shown promising results in reduction of acute care service use by patients in RACHs but may lack provision of ongoing care and continuity of care (1).

Opportunities

Examples of models funded in Australia:

- Residential In-Reach Services in Victoria deliver medical and nursing care to RACHs to reduce emergency department demand.
- Programs using paramedics who visit RACHs to deal with acute problems such as minor suturing or replacing percutaneous endoscopic gastronomy (PEG) tubes.
- Silverchain's Home Hospital Program, which provides hospital level services (e.g. intravenous antibiotics) in community settings including in RACHs.
- Geriatric Flying Squads

Hospital Led Model Example:

Wombat Point is a Multi-Purpose Health facility led by a State health service in a rural area. The facility has a 28-bed residential aged care home co-located with the hospital.

Care to residents is delivered by staff at the health service, including general practice care. The GPs delivering care have employment arrangements directly with the hospital.

Upon escalation of clinical needs, the residents do not need to transfer to hospital, instead care comes to them, by way of the specialists from the hospital who treat them from their usual bed location.

This is a small country town of approximately 3000 people.

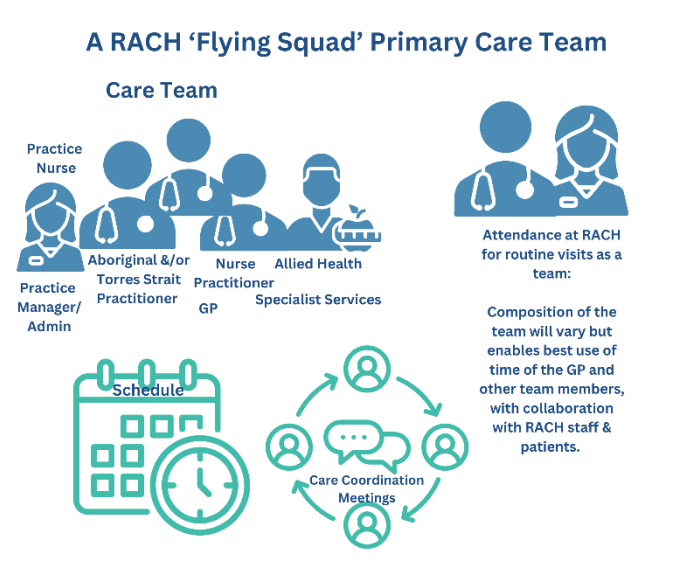
Section 3 – Business Models

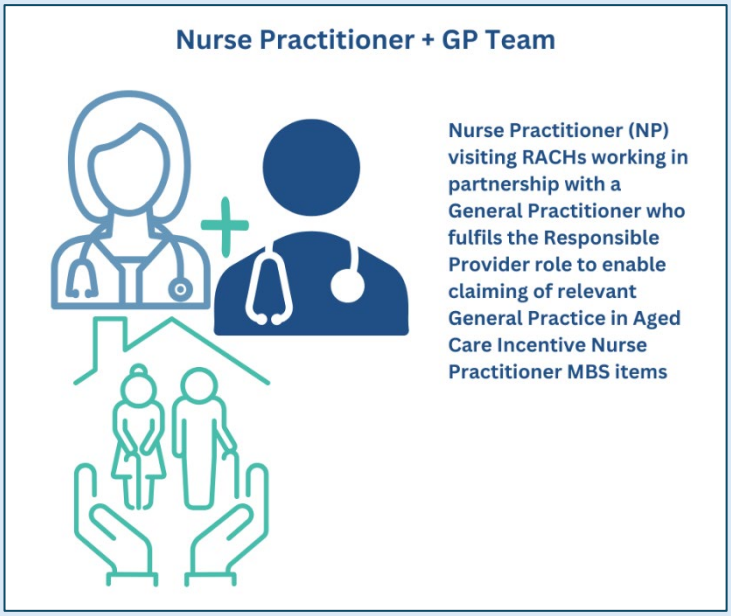
Whilst the service models describe the way in which primary care is operationalised within residential aged care homes, there are variations in business structures and funding arrangements which could support service delivery under these models. This section details several business models which currently exist in the Australian setting.

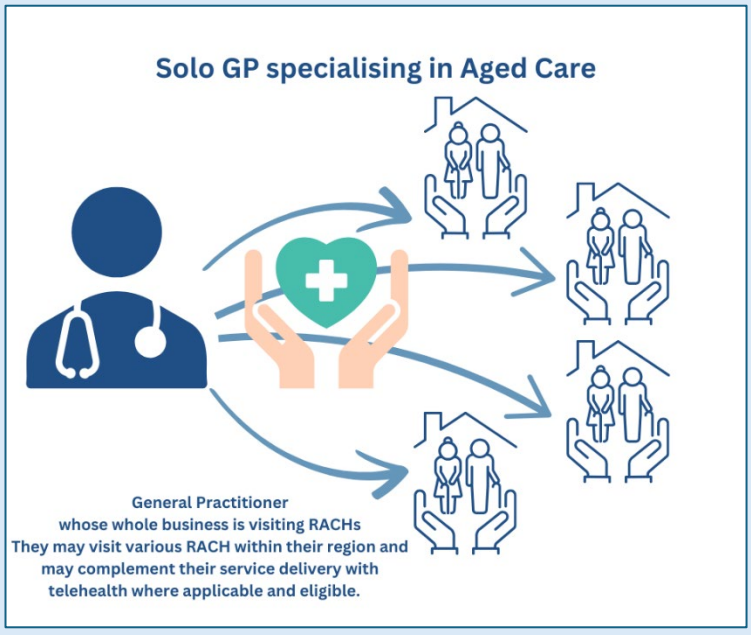
Whilst we have indicated how various business models have aligned with relevant service delivery models, this is not absolute. New business models are emerging and will continue to emerge as a result of changes to incentive programs (e.g. The General Practice in Aged Care Incentive), accreditation standards for non-traditional practices and changes to the primary care system funding structures. It is anticipated that continued exploration and evaluation of these models will assist in increased understanding of the barriers and enablers that various models offer for service providers and care recipients.

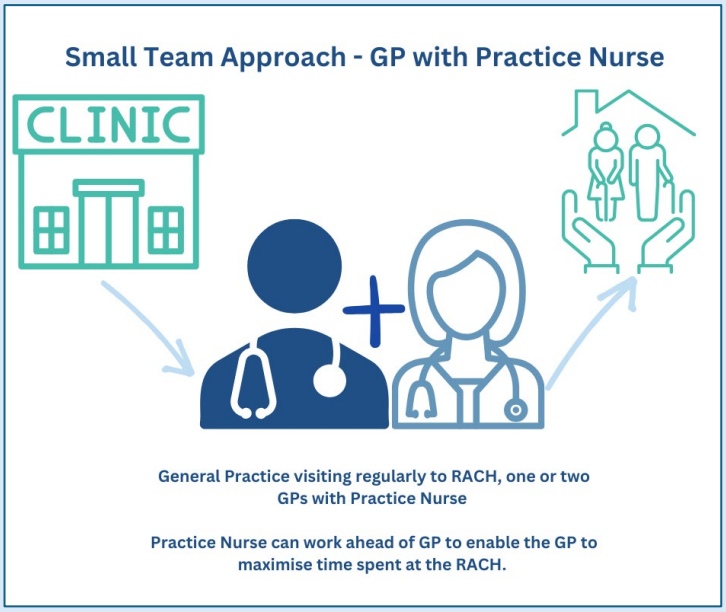
For further reading:

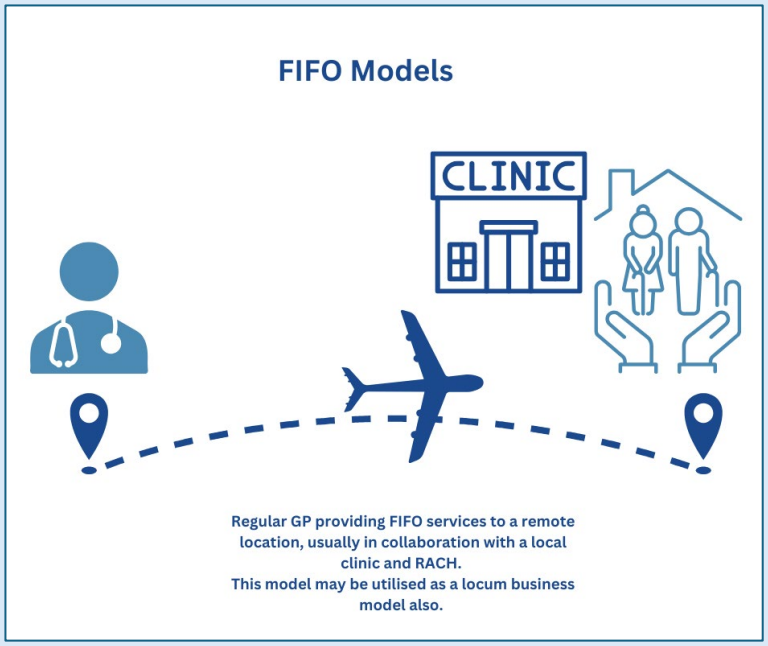
- A new model of care and in-house general practitioners for residential aged care facilities: a stepped wedge, cluster randomised trial - Haines - 2020 - Medical Journal of Australia - Wiley Online Library
- RACGP - Models of GP services in residential aged care facilities

Business Model	Description
	Primary care teams organised as structured flying squads. A group of highly skilled aged care clinicians drawn from multiple practices or a singular practice. The flying squad may be its own business entity as a sub service of an accredited practice. It offers regular planned visits to multiple RACHs, supported by systems for care planning, care coordination, acute care management etc. These business arrangements are common in the in-reach model, the aged care speciality model and models supported by state-funded health services.

Business Model	Description
	Nurse-led models or independent nurse practitioners providing primary care services for residents in RACHs. NPs working in aged care experience a broad scope of practice supporting with both clinical care and coordination roles (13). The role is evolving, largely due to shortages of medical workforce (13). Models of NPs partnering with a General Practitioner to deliver care in aged care settings are emerging. Funding options in support of these models pose barriers to recruiting and sustaining NPs, however there are growing instances where NPs are contracted by either the GP or RACH. Appendix 1 identifies the MBS items available for NPs.

Business Model	Description
	A solo practicing GP who specialises in providing primary care services to residents living in RACHs within a specified region. They may have ongoing working partnerships in place at several RACH locations and may not have a 'bricks and mortar' clinic. These business models are now eligible for accreditation. Further details can be viewed at here.

Business Model	Description
	A general practice may have a practice nurse working in partnership with a GP when visiting a RACH. The practice nurse's role can be varied including taking patient observations, point of care testing (e.g. INR, ECG etc), care planning documentation and liaison with the RACH staff. This can assist in maximising the time spent at the RACH and may assist with increasing the number of residents able to be seen in one visit. This model may be applicable to all of the service models listed earlier, however is commonly seen in the cluster model, the aged care speciality model and the collaborative care model.

Business Model	Description
	This model has multiple modalities and variations based on the needs of the geography, regional demographics and proximity to health services. Pop up clinics are common in remote locations in Australia, including in remote Aboriginal communities. Locum general practitioners travel to the community to provide a block of time of clinical practice for the community, both from a general practice/primary health care clinic and outreach to locations such as a RACH. This model is seen more in the specialist in-reach model, the aged care speciality model, the collaborative care model and the cluster model.

Section 4 – Enablers of Models of Care

The models described above are evolving in response to a range of factors. Changes to models of care and the way that care is structured and delivered fluctuates in response to workforce changes (including variations in access, skill mix and discipline), changes to Government incentives and policies, the emergence of innovative technologies and digitisation and localised factors such as arrangements with hospitals or collaborative care programs. Understanding how these factors can act as enablers may assist to improve options for care delivery. Assessing the complex interaction between funding arrangements, workforce and technology can assist in identifying risks and the opportunities that may present in terms of efficiency and capacity (25). This section explores current incentives, workforce considerations and advances in technologies as key enablers for contemporary improvements in models of care.

4.1 General Practice Care Incentives

In recognising the improvements required to the primary care system and in accordance with recommendations under the Strengthening Medicare Taskforce Report, changes are being made to existing primary care incentives to improve consumer access to quality primary care. Incentives can influence the way in which care is delivered and thus it is helpful to understand the breadth of incentives and their relationship to residential aged care. The introduction of voluntary patient registration, called MyMedicare, is one approach that the Government is taking to support improved continuity of care and promote a strengthened relationship between the patient and their care team. In the years to come, we will see greater investments in MyMedicare that help to benefit the consumer and care providers.

At present, the following incentives may be considered by General Practices who deliver care to residents in RACHs:

- **General Practice in Aged Care Incentive** - The General Practice in Aged Care Incentive aims to improve access to quality, proactive general practice care for residential aged care home residents. Under the incentive, eligible practices and providers registered in MyMedicare will receive incentives for providing their registered patients proactive face-to-face visits, regular, planned reviews and coordinated care planning. Information about the General Practice in Aged Care Incentive including the guidelines is available here: **health.gov.au/our-work/gpaci**
    - **Links for General Practice in Aged Care Incentive Resource Planning tool - GPACI Resource Planning Tool**
    - **Business modelling information for General Practice in Aged Care Incentive (MBS User guide): GPACI MBS User Guide**

- **Care planning options** – A guide to care planning for the General Practice in Aged Care Incentive **care-plan-contribution-template.docx**. Items available to claim include: **GPACI MBS User Guide**.

- **Bulk Billing Incentives** – the Government has committed to improving bulk billing incentive eligibility and is introducing a new program in November 2025 to support practices to bulk bill all eligible services. Read further here: **https://www.health.gov.au/our-work/upcoming-changes-to-bulk-billing-incentives-in-general-practice**

4.2 Workforce

The proportion of GPs aged 55 years and older increased from 37% in 2018 to 49% in 2023 (14). Further, nursing shortages are also anticipated and will further exacerbate recruitment and retention challenges, particularly in regional areas (15). This ageing of the GP workforce and shortages of key professions are known risks to sustainable health care.

4.2.1 Current and Emergent Roles

Many of the models above promote improved utilisation of new and existing primary care workforce supports. Craswell 2023 (10) determined that onsite **Nurse Practitioners (NPs)** within RACHs improved communication with GPs and hospital staff, supported RACH staff and they were able to provide onsite primary care (10). Evidence from Canada has shown how NPs used in aged care enhanced interprofessional care and decreased physician burnout and stress (16). However, workforce barriers to finding, securing and paying nurse practitioners to work onsite in RACHs prohibit rapid uptake of the NP model. A supportive program for existing registered nurses working in Aged Care to extend their scope of practice and embark on nurse practitioner training with a focus on aged care, could improve access to primary care for older Australians living in residential aged care. Models of nurse practitioners supporting primary care delivery are emerging. **Appendix 1** houses links to the NP MBS item numbers which can underpin functional business models for NPs working in RACHs.

Practices who involve **Practice Nurses and Aboriginal Health and/ or Torres Strait Islander Practitioners** to assist in delivering and organising care derive value from these staff in tasks such as care planning, disease/prevention screening, care monitoring/tracking. Their roles as contributors to the care team are recognised by both the MBS and the General Practice in Aged Care Incentive. See **Appendix 1** for further information.

Furthermore, the recognition of the role of **general practice registrars** in delivering primary care in aged care is growing (20). These clinicians are a crucial team member in RACHs (20) with responsibilities that support conducting comprehensive health assessments, supporting palliation, reviewing clinical nursing notes, symptom screening and proposing fresh medical perspectives (20,24). Various resources exist promoting the role and supports needed for registrars to develop expertise in confidence in aged care primary care provision. These can be viewed in **Appendix 3**.

4.2.2 Team -based care

Cohesive teams are known to produce quality care, team performance and workforce satisfaction (17). Skilled and cohesive teams are underpinned by interprofessional education and learning, organisational policy and practice support systems (17). Working culture, through use of communication strategies, conflict resolution supports/policies and shared decision-making processes also support to create effective primary care teams (17).

Appendix 2 include a range of information and resources and a checklist relevant to supporting improved team cohesion. Recognising the need to invest in dedicated time to build and harness team cohesiveness is recommended.

4.3 Innovative Technologies

Emerging trends in technologies such as artificial intelligence, wearable devices, telehealth and remote monitoring systems can assist in supporting and optimising primary care delivery in RACHs. Their use in healthcare settings is rapidly advancing.

4.3.1 Use of telehealth and remote monitoring in primary care/RACH models:

Telemedicine has been shown to increase access to healthcare (25). Uses for telemedicine include remote patient surveillance, earlier access to prescriptions and decision support during times of acute care (25). For aged care settings, integrating telemedicine into workflows within primary care models can mobilise care and support when capacity is challenged. In one trial, telehealth reduced ambulance transfer to hospital (8). Examples include:

- Specialist outreach models - enabling specialised advice to be received when face-face proximity cannot be attained,
- Fly in Fly out arrangements – enabling follow up and continuity of care by clinicians when they are out of region,
- Collaborative care models – where practice nurses offer face-face routine care and conduct screening and care planning, with the GPs supporting the service virtually,
- as a regular modality of care for RACHs in regional settings and as solutions to workforce shortages.

Digital Case Study:

Support to expand telehealth options and opportunities by PHNs are seeing various digital investments being made to improve care access and experience. Read on for further information and to see examples of these in practice Telehealth in Residential Aged Care project delivered by Healthy North Coast PHN:

Residential Aged Care Virtual Care Project | Healthy North Coast

4.3.2 Artificial intelligence supporting primary care service delivery in aged care:

The use of **artificial intelligence (AI)** in residential aged care is emerging at a rapid pace in response to workforce shortages, with uses seen in health monitoring, risk detection, care planning and companionship. An analysis of literature has identified the following opportunities through which AI could support care in RACHs:

- Clinical support:
  - AI enabled sensors and predictive algorithms continuously monitor residents to detect health issues or risks (26, 27)
  - decision support (26)
  - supported chronic disease monitoring, (26)
  - assessment of frailty and falls risk (26)
  - management of social isolation (23, 27)
  - conducting medication reminders (28)
  - conducting engagement for people with dementia to manage behavioural symptoms and provide stimulation (26)

- Care support:
  - conducting routine reminders e.g. reminding residents to complete activities of daily living (28)
  - reducing social isolation through assistive robotics (29)
  - Leading group exercise and entertainment (30)
  - robotic lift devices (29)
- Administrative support:
  - generating rosters (28)
  - creating shift plans (28)

AI in aged care case examples:

Generative AI supporting improved care planning and administrative tasks:

Improving the quality of aged care with generative AI | CGI Australia

Health monitoring in aged care:

Wearable sensing technology coming to the fore to improve wellbeing in aged care – Aged Care Insite

Section 5 – Conclusion

This document outlines a number of current and emerging service delivery and business models that have been identified in relation to increasing access to primary care for residents in Residential Aged Care Homes. The varied models have potential to:

- enhance continuity of care for residents
- promote proactive/preventative care
- foster ongoing connections to the community
- reduce burden on individual practitioners through team-based approaches
- support sustainability of care for residents
- support comprehensive care through multidisciplinary teams
- Leverage the skills and interest of clinicians with specialised and advanced skills
- Support business growth for practices
- Enhance efficiency through use of technologies such as telehealth
- Provide reliable primary care support for RACH staff
- Prevent unnecessary hospitalisations
- Increase access to primary care for residents, particularly in thin markets/rural areas and during after-hours periods.

The manner in which various service delivery and business models are put together is dependent on a large range of factors. Some of these include challenges and enablers such as:

- health and service needs in particular regions or RACH settings,
- general practice motivation to begin or enhance service provision in RACHs,
- workforce availability,
- appetite for partnership between RACHs and General Practices,
- proximity between providers and RACHs
- systems for sharing information and coordination of care to facilitate quality care
- preferences in relation to resident choice
- funding incentives and business model viability
- existing and complementary service availability (e.g. after-hours services, State Government/local health service support)

We have provided information and references in relation to key enablers relating to General Practice care incentives, workforce (current and emergent roles, team cohesion) and innovative technologies (telehealth and remote monitoring and Artificial Intelligence).

We hope that the range of information presented is useful in stimulating ideas and the development of new or changed models of care that improve access to primary care for RACH residents.

Section 6 – References

1. Reed RL. Models of general practitioner services in residential aged care facilities. Aust Family Physician. 2015 Apr;44(4):176-9. PMID: 25901399.
2. Ibrahim JE, 2018, Residential aged care: there is no single optimal model. The Medical Journal of Australia, Volume 208, Issue 10, 420-462
3. Australian Institute of Health and Welfare, 2024, GEN fact sheet 2022–23: People's care needs in aged care, AIHW, Australian Government.
4. Ferrah N, Ibrahim JE, Kipsaina C, Bugeja L: Death following recent admission into nursing home from community living: a systematic review into the transition process. J Aging Health 2018; 30: 584-604
5. Mitchell G, Melaku M, Moss A, Chaille G, Makoni B, Lewis L & Mutch A. Evaluation of a commissioned end-of-life care service in Australian aged care facilities, Progress in Palliative Care, 2022, 30:4, 229-237, DOI: 10.1080/09699260.2021.1905146
6. Meade C, Ward B, Cronin H, 2016, Implementation of a team model for RACF care by a general practice. Australian Family Physician, 45 (4).
7. Haines TP, Palmer AJ, Tierney P, Si L, Robinson AL. A new model of care and in-house general practitioners for residential aged care facilities: a stepped wedge, cluster randomised trial. The Medical Journal of Australia. 2020; 212 (9): 409-415. Doi: 10.5694/mja2.50565
8. Trankle, S.A., Reath, J. Afterhours telehealth in Australian residential aged care facilities: a mixed methods evaluation. BMC Health Serv Res 23, 1263 (2023). https://doi.org/10.1186/s12913-023-10257-5
9. Ervin K, Reid C, Moran A, Opie C, Haines H. Implementation of an older person's nurse practitioner in rural aged care in Victoria, Australia: a qualitative study. Hum Resource Health. 2019 Nov 1;17(1):80. doi: 10.1186/s12960-019-0415-z. PMID: 31675960; PMCID: PMC6824051.
10. Craswell 2023 Alison Craswell, Kaye Coates, Colleen Johnston-Devin, Deepa Sriram, Marc Broadbent, Marianne Wallis, Developing a nurse practitioner to work in residential aged care: A qualitative evaluative study, Collegian, Volume 30, Issue 3, 2023,Pp 457-464, ISSN 1322-7696, https://doi.org/10.1016/j.colegn.2022.12.006.
11. Cameron ID, Steinke H, Kurrle SE. A new model of care and in-house general practitioners for residential aged care facilities - Letter. The Medical Journal of Australia. 2021; 215 (1): 44-44. Doi: 10.5694/mja2.51120
12. Rayner JA, Fetherstonhaugh D. What factors influence nursing home use of hospital avoidance programs? An interview study. Journal of Advanced Nursing. 2022 Feb;78(2):510-522. doi: 10.1111/jan.15051. Epub 2021 Oct 7. PMID: 34617613.
13. Peters MDJ, Marnie C. Nurse practitioner models of care in aged care: a scoping review protocol. 2022. JBI Evidence Synthesis, 20(8):p 2064-2070.
14. Royal Australian College of General Practitioners. RACGP, Health of the Nation Report, 2024, RACGP - Current workforce characteristics.
15. PWC, Planning for the healthcare workforce of the future. Planning for the healthcare workforce of the future. Accessed Jan 2025.
16. Campbell T.D.,Bayly M., Peacock S. Provision of resident-centered care by nurse practitioners in Saskatchewan long-term care facilities: qualitative findings from a mixed methods study. Res. Gerontol. Nurs., 13 (2) (2020), pp. 73-81
17. Naccarella L, Greenstock LN, and Brooks PM. A framework to support team-based models of primary care within the Australian health care system. Med J Aust; 2013, 199 (5): S22-S25.
18. Royal Australian College of General Practitioners. RACGP, Supporting sustainable GP-led care for older people. 2022, RACGP - Supporting sustainable GP-led care for older people.
19. Bekbolatova M, Mayer J, Ong CW, Toma M. Transformative Potential of AI in Healthcare: Definitions, Applications, and Navigating the Ethical Landscape and Public Perspectives. Healthcare (Basel). 2024 Jan 5;12(2):125. doi: 10.3390/healthcare12020125. PMID: 38255014; PMCID: PMC10815906.

20. Royal Australian College of General Practitioners. RACGP aged care clinical guide (Silver Book). 5th edition. Part B. Collaboration and multidisciplinary team-based care. 2020.
21. Peters MDJ, Marnie C, Helms C. Enablers and barriers to nurse practitioners working in Australian aged care: A scoping review. International Journal of Nursing Studies, 2024; 158, 104861.
22. Aged Care Quality & Safety Commission, Comprehensive care | Aged Care Quality and Safety Commission, accessed 2 April 2025.
23. Padhan S, Mohapata A, Ramasamay SK, Agrawal S. Artificial Intelligence (AI) and Robotics in Elderly Healthcare: Enabling Independence and Quality of Life**,** 2023; 15(8):e42905.
24. General Practice Training Tasmania, 2018, Aged Care Teaching & Opportunities for Registrars (ACTOR). www.racgp.com.au, accessed 3 June 2025.
25. Deloitte. Workforce ecosystems, a new strategic approach to the future of work. 2021. Practical guide to workforce ecosystems | Deloitte Insights. Accessed 9 April 2025.
26. Shiwani T, Relton S, Evans R, Kale A, Heaven A, Clegg A, 2023. New Horizons in artificial intelligence in the healthcare of older people. *Age and Ageing*, Volume 52, Issue 12.
27. Sarfraz, Si, Iqbal. 2023. Artificial Intelligence Tools and Applications for Elderly Healthcare - Review. In *2023 9th International Conference on Computing and Artificial Intelligence (ICCAI 2023), March 17-20, 2023, Tianjin, China*. ACM, New York, NY, USA, 7 Pages.
28. Orlov, 2024. The future of AI in senior living and care. Future of AI in Senior Living and Care.pdf. Accessed 8 May 2025.
29. Insightace Analystic. Robotic Nurses Market worth $2777.61 Million by 2031 – Exclusive Report. April 2023. Accessed 8 May 2025. [Latest Edition] Robotic Nurses Market worth $2777.61 Million by 2031 – Exclusive Report by InsightAce Analytic
30. Falcon S. 6 Nurse AI Robots That Are Changing Healthcare in 2025. 6 Nurse AI Robots That Are Changing Healthcare in 2025. Accessed 8 May 2025.

Appendix 1 - MBS Items

1.1 Nurse Practitioner Standard Items

Nurse practitioner MBS item detail are contained within the following MBS categories:

- **Category 8 - Group M3 Allied Health Services**
- **Category 8 - Group M14 - Nurse Practitioners**
- **Category 8 - Group M18 - Subgroup 5 Nurse practitioner telehealth services**
- **Category 8 - Group M18 - Sub Group 10 Nurse practitioner phone services.**

The items include services for:

- attending and participating in chronic disease management case conference services
- face to face attendances
- telehealth attendances
- phone attendances

1.2 General Practice in Aged Care Incentive MBS User Guide

GCPHN MyMedicare - GP Aged Care Incentive (GPACI) MBS User Guide

Appendix 2 - Resources to support team effectiveness

2.1 Team Effectiveness:

Five principles to assist team effectiveness include: shared purpose and goals, clarity and understanding of roles and responsibilities, mutual trust, effective communication and measuring team function (17). Translating theory to practice requires planning and dedicated time to employ strategies for team cohesiveness.

Putting these into practice may be assisted by the following checklist:

Team Effectiveness Tips:

Theory	In practice
Shared purpose and goals	✓ Engage all team members to create a vision and set goals to achieve this. ✓ Facilitate joint learning and education. ✓ Problem solve together as a team at each meeting.
Clear roles and responsibility	✓ Discuss role responsibilities regularly and openly. ✓ Use case examples to show clear role delineation.
Mutual trust	✓ Show appreciation & model respectful behaviour. ✓ Conduct team building activities. ✓ Offer gratitude for time given by staff to contribute and engage in teamwork.
Effective communication	✓ Ensure regular communication for example through huddle &, team meetings. ✓ Offer honesty and transparency. ✓ Promote listening and respect without judgment.
Measuring process and outcomes of team function	✓ Structure collaboration so it's not left to chance. ✓ Track goals, reflect regularly and celebrate wins. ✓ Set team values and share accountability for these.

(Sources:18, 17).

2.2 Teaching primary care teamwork:

A conceptual model of primary care team performance based on research identifying.

Teaching primary care teamwork: a conceptual model of primary care team performance - PMC

2.3 RACGP Aged Care Clinical Guide:

The RACGP Aged Care Clinical Guide (silver book) (20) discusses optimal care for older people, particularly in residential aged care facilities. It outlines that collaboration and collaborative care with multiple health professionals from different professional backgrounds is essential to improving health outcomes.

RACGP - RACGP aged care clinical guide (Silver Book)

Appendix 3 – Resources to promote the role of registrars in aged care

Silver Book - Part C - Teaching and mentoring in aged care – specific information for registrars

RACGP - Teaching and mentoring in aged care

Exploring opportunities for general practice registrars to manage older patients with chronic disease: A qualitative study

RACGP - Opportunities for general practice registrars to manage older patients with chronic disease

Silverchain – Training program for Resident Medical Officers (RMOs) and registrars, including specific training in palliative care and aged care

Silverchain - Training education and resources

Review Cycle of the Models of Primary Care in Residential Aged Care Homes (RACHs)

PHNs have jointly developed this resource through the National PHN MyMedicare Implementation Program. Review of the Original National PHN MyMedicare branded resource will occur 6 months or as required.

This document is **Version 1**, published **19 August 2025**. The next review is due **February 2026**.

Printed copies of this resource are uncontrolled and may not contain the most up to date information.

If you have any feedback on this resource, please contact practicesupport@gcphn.com.au