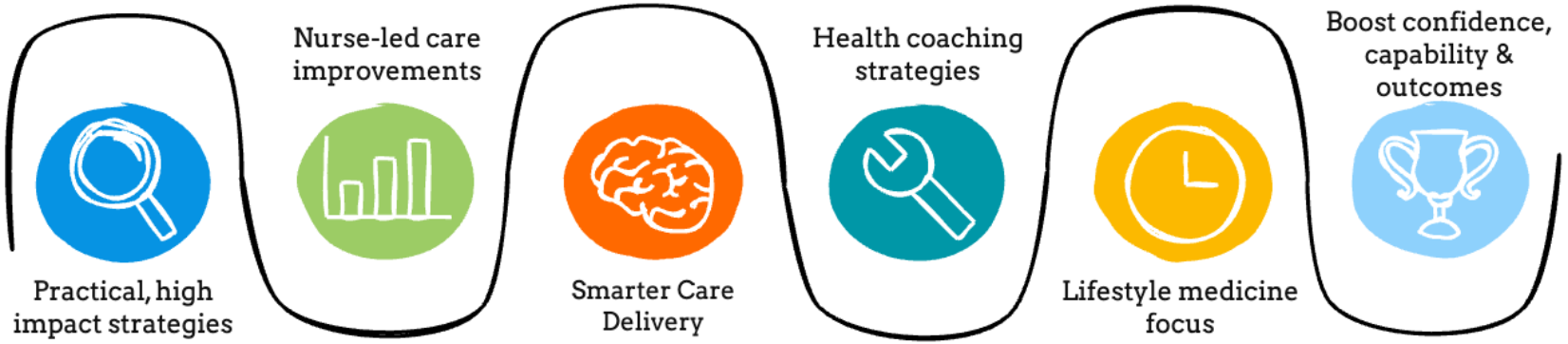
Transforming Clinical Care | The Webinar Series



Webinar #7 of 7 (Recorded)

Primary Care Innovation

GPs in Aged Care Incentive
&
End of Life Pathway

Funded by Healthy North Coast through the North Coast PHN program

Acknowledgement of Country

Primary Care Innovation acknowledges Traditional Owners of Country throughout Australia and recognizes the continuing connection to lands, waters and communities.

We pay our respect to Aboriginal and Torres Strait Islander cultures, and to Elders past and present.

Primary Care Innovation

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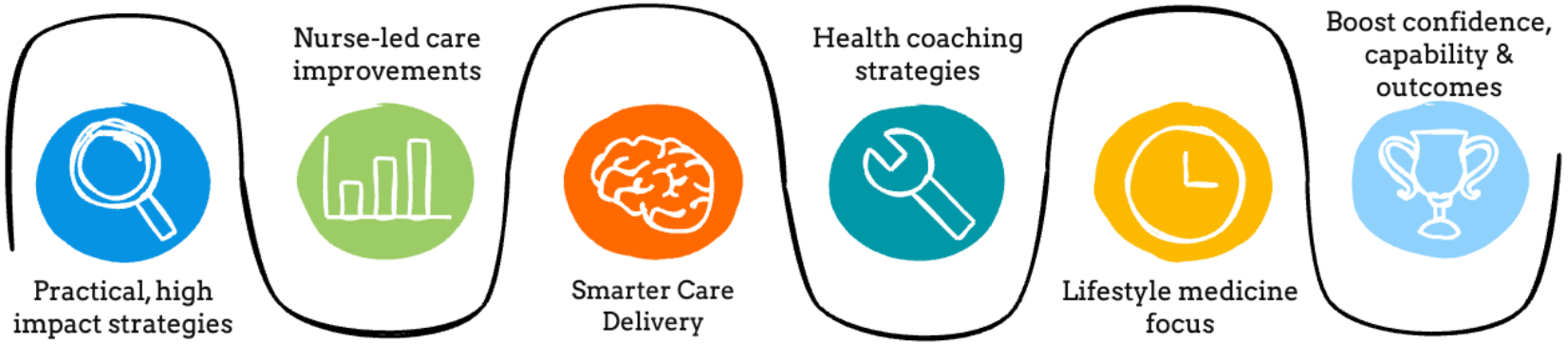

The Webinar Series

1. A Framework for nurse-led Clinics
2. Planning, Goal Setting with patients & Health Coaching
3. Patient Engagement via Coaching Voices
4. Optimising Health Assessments
5. Optimising GPCCMPs
6. Optimising QI-PIP and Indigenous Health Incentives
7. GPiACI & End of Live Pathway

Primary Care Innovation

Today's Session

Part 1 — GPACI

- Program overview & eligibility
- Servicing requirements & payments
- Nurse roles & practice workflows
- Team discussion prompts

Part 2 — End-of-Life Pathway

- What is the EoL Pathway?
- Eligibility & the GP's role
- Completing the form & referral process
- Practice team coordination

Overview: Why GPACI?

- Response to the Strengthening Medicare Taskforce recommendations
- Addresses fragmented care for older Australians in residential aged care homes (RACH)
- Goal: better continuity, integrated person-centred care, and proactive management
- Incentivises GP practices to invest in structured RACH engagement
- Delivered through Practice Incentives Program (PIP) — assessed quarterly by Services Australia
- **AoB changes from 1 July 2026 are a significant stressor**

Eligibility | Practice Registration

Four requirements must all be in place before any payments are possible:

1

General Practice or eligible organisation

Must be a general practice or a practice eligible for exemption under the MyMedicare framework https://www.health.gov.au/our-work/gpaci

2

Organisation Register PRODA

Practice registered in the Organisation Register (separate to MyMedicare registration)

3

MyMedicare + banking details

Practice registered in the MyMedicare program — including nominated bank account details for payment

4

GPACI sub-program registration

Specifically registered in the GP in Aged Care Incentive sub-program within MyMedicare

Eligibility | Responsible Provider (RP)

- The Responsible Provider (RP) is the GP (or eligible practitioner) nominated to deliver ongoing care to a RACH resident
- Must be linked to the practice in MyMedicare - bank account assigned
- One RP per patient (the patient's 'regular GP' for MyMedicare purposes)
- The RP does not need to be the only treating clinician - other providers can deliver eligible services
- If a patient's RP changes, retrospective adjustments to payments may apply - keep records current
- Practices can have multiple RPs (e.g. GPs who each hold a panel of RACH patients)
- The RP is accountable for the two required care planning services each year

The Care Team

GPACI is a team-based model — the GP does not work alone

Responsible Provider (GP)	Practice Nurse	RACH Staff	Practice Manager
• Care planning • clinical oversight • authorisation of services	• Nurse consultations 10987/10997 • health assessments • care coordination • Nurse Practitioner	• Day-to-day resident care communication pathway • flagging changes	• Service tracking, audit • MyMedicare admin • billing oversight

Servicing Requirements | 12-Month Period

Minimum 10 eligible services per patient over 12 months — composition matters

MANDATORY SERVICES (2)

2 x Care Planning services by the RP each year

- Contribution to Care Plan / Review (731, 232, 92027, 92058)
- RMMR (903 | 249)
- Multidisciplinary case conference (735-758 | 235-240)
- Health Assessment (701-707)
- 2 services are REQUIRED to unlock the annual payment

REGULAR SERVICES (8 minimum)

- At least 2 per quarter, each in separate calendar months
- Level B-E attendance at RACH
- Practice nurse consultations (10997 & 10987)
- Non-urgent after-hours services
- Nurse Practitioner services (82205-82215)
- MMM4-7: Regular telehealth (91800-91926) - up to 4 per year

Assessment Periods & Payments

Q1 Jul-Sep	Q2 Oct-Dec	Q3 Jan-Mar	Q4 Apr-Jun

Assessed by Services Australia 5 working days after end of each period

When	Who	Amount Per Patient	Condition
Each quarter (Q1-Q3)	Responsible Provider (RP)	$75/quarter ($300/yr)	Meet eligibility + 2 eligible services
Each quarter (Q1-Q3)	Practice	$32.50/quarter ($130/yr)	Meet eligibility + 2 eligible services
Q4 payment	RP + Practice	As above	Over 12 months: 8 regular + 2 care planning services completed
MMM3 rural loading	RP + Practice	+20%	MMM3 location
MMM4–5 rural loading	RP + Practice	+30%	MMM4-5 location
MMM6–7 rural loading	RP + Practice	+50%	MMM6-7 location

Ensure billing is up to date! Retrospective adjustments apply for changes in circumstance.

How Practice Nurses Can Make GPACI Work

Nurses are central to meeting servicing requirements and making the program sustainable

Delivering eligible services

Nurse consultations 10987 & 10997 count as regular services. Nurses can visit RACH residents independently and contribute to the quarterly service count.

Coordinating care planning

Prepare patients and documentation for GP-led care planning visits - gather clinical data, update chronic disease registers, and liaise with RACH staff beforehand.

Health assessments

Nurses can conduct or assist with Comprehensive Medical Assessments (701-707, 715) and annual chronic disease reviews (731) - key components of the care planning requirement.

RACH communication

Establish a regular communication channel with RACH staff. Nurses are often the primary liaison - flagging changes in resident condition, coordinating medication reviews.

Service tracking & audit

Maintain a register of GPACI-enrolled patients, services delivered per quarter, and upcoming care planning due dates.

Telehealth coordination

For MMM4-7 practices, nurses can coordinate and support telehealth consultations - helping residents access GP care remotely (up to 4 per year under the program).

Team Discussion | Questions to Raise in Your Practice

- **Q** Will it work better to group care planning visits together or schedule them individually? What are the pros and cons?
- **Q** Who is responsible for tracking progress and flagging when services are falling behind?
- **Q** How often will you audit your service register - monthly? quarterly?
- **Q** How do you ensure every patient receives an eligible service in the FIRST month of each quarter?
- **Q** What are the communication pathways with RACH staff, and who owns that relationship?
- **Q** How do we best use our nursing team to meet regular service requirements?
- **Q** How do we embed uploading of Shared Health Summaries into the workflow (and meet eHealth targets)?

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Part 2: End-of-Life Pathway

A new Support at Home program for patients in their final months

What Is the End-of-Life Pathway?

A new short-term funded pathway under the Support at Home program, launched 1 November 2025

Who it's for

Older Australians diagnosed with 3 months or less to live who wish to remain at home (not in a RACH)

What it provides

$25,000 over 12 weeks for personal care, domestic assistance and general nursing. Funding can extend to 16 weeks if unspent budget remains

What it doesn't replace

Works alongside existing state/territory palliative care services (symptom management, specialist palliative care). Does not replace clinical palliative care

VAD and this pathway

Access to voluntary assisted dying does not affect eligibility - both services can be accessed simultaneously if criteria are met

Eligibility Criteria | End-of-Life Pathway

All criteria must be met. Assessment is completed by a GP or nurse practitioner.

1	Age	Aged 65 years or older. Aboriginal and Torres Strait Islander people, or those experiencing homelessness: 50 years or older.
2	Life expectancy	Estimated life expectancy of 3 months or less, confirmed by a medical practitioner or nurse practitioner.
3	AKPS Score	Australian-modified Karnofsky Performance Status (AKPS) score of 40 or below, indicating significant functional decline.
4	Home-based care	The patient wishes to remain at home (not transition to RACH) - this is a home care program.
5	Aged care eligibility	Must meet general entry criteria for government-funded aged care services under the Support at Home program.

The Australian-Modified Karnofsky Performance Status (AKPS)

A validated functional status scale used to determine clinical eligibility. Score of 40 or below required.

Score	Description	Relevance
100-80	Normal activity; no evidence of disease or minor symptoms	Not eligible
70-60	Reduced activity; some assistance needed; considerable help required	Not eligible
50	Considerable assistance needed; frequent medical care	Borderline - review
40	**Disabled; requires special care; bed-ridden <50% of time**	**Threshold - eligible if prognosis also met**
30-10	**Severely disabled; hospitalisation indicated; actively dying**	**Eligible (if under 65 criteria met)**

GPs complete and sign the End-of-Life Pathway form, which captures the prognosis and AKPS score.

The GP's Role | Completing the End-of-Life Pathway Form

Step 1	Identify the patient	Confirm the patient meets age criteria and has a terminal diagnosis with estimated prognosis of 3 months or less
Step 2	Assess AKPS score	Document functional status - score must be 40 or below at time of assessment
Step 3	Complete the form	Complete the End-of-Life Pathway Form (available on health.gov.au) - captures medical condition, prognosis and AKPS score
Step 4	Submit or provide the form	Upload via 'Make a Referral' or 'GP e-referral' on My Aged Care, OR provide a signed copy to the patient/carer/representative for submission
Step 5	Aged care assessment	An aged care assessor conducts a priority home assessment - typically within days, not weeks. Patient receives a Notice of Decision and support plan

The form is available on the My Aged Care website. Only a GP, non-GP specialist, or nurse practitioner can sign it.

What the $25,000 Budget Covers

Funding is designed for rapid escalation in care needs - services begin within days of approval

FULLY GOVERNMENT FUNDED	MAY REQUIRE CONTRIBUTION
• Clinical supports (nursing, allied health) • Medication management • Equipment and assistive technology • Palliative care services	• Independence and everyday living services • Domestic assistance and personal care • Home modifications • Transport and social support

If the patient outlives 12 weeks, the budget extends to 16 weeks (if funds remain). Care is then reassessed for transition to an ongoing Support at Home classification.

Advance Care Planning & Palliative Support

The EoL Pathway funds home support services - advance care planning and symptom management sit alongside it

- Advance Care Directives (ACDs) should ideally be completed before the patient loses capacity
- The EoL Pathway supports state and territory palliative care services - refer to specialist palliative care where symptom burden is complex
- National Palliative Care Service Directory: accessible via palliativecare.org.au - use to identify local services
- ELDAC (End of Life Directions for Aged Care): provides toolkits, staff training resources and clinical guidance - available to home care workers and practice staff
- The EoL Pathway care partner (assigned by the provider) coordinates services - the GP and practice team should establish a clear communication line with this person
- After-hours plans are critical: ensure the patient and carer have a clear plan for distressing symptoms outside business hours (including an after-hours GP contact)

Case Scenario | Discussion

Margaret, 78, lives at home with her husband. She has been your patient for 12 years.

Margaret has advanced bowel cancer with liver metastases. Her oncologist has advised a prognosis of 8-10 weeks. She is increasingly bed-bound (AKPS ~40) and her husband is struggling with carer burden. Margaret's strong preference is to die at home.

She does not currently receive any home care services and does not have a current Advance Care Directive.

- Is Margaret eligible for the EoL Pathway? What steps would you take today?
- Who in your practice team is involved, and what is each person's role?
- What additional supports would you want in place for Margaret and her husband?

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Key Resources

End-of-Life Pathway (My Aged Care)	*myagedcare.gov.au/aged-care-programs/end-life-pathway*
DoHDA Fact Sheet for GPs & NPs	*health.gov.au - search 'End-of-Life Pathway fact sheet doctors'*
EoL Pathway Form (health.gov.au)	*health.gov.au/sites/default/files/2025-10/end-of-life-pathway-form_0.pdf*
ELDAC - End of Life Directions for Aged Care	*eldac.com.au*
Palliative Care Australia - EoL Pathway position statement	*palliativecare.org.au*
GPACI - Health.gov.au	*health.gov.au/our-work/gpaci*
MyMedicare program information	*servicesaustralia.gov.au - search 'MyMedicare'*
Transforming Clinical Care Series resources	*primarycareinnovation.com.au/transforming-clinical-care*

Thank you!

Thank you for joining the Transforming Clinical Care Series

Please take a moment to complete the brief evaluation

Recording and resources available at: primarycareinnovation.com.au/transforming-clinical-care

This program is funded by Healthy North Coast / North Coast PHN