

Nursing in General Practice Business Case Models

This information is provided to support Divisions of General Practice in their discussions with general practices of the benefits and implications of employing a practice nurse.

The package contains:

- Case studies illustrating the roles performed by nurses in a number of practices. These case studies describe real practices and depict a range of different models of nurse utilisation in general practice.
- Business Case Models for large and small, urban, rural and solo GP practices, suggesting how nurses can be introduced into general practice and how this may affect the financial performance of the practice.
- An overview of the four phases of the Project.
- A detailed description of the methodology utilised in developing the Business Case Models.
- The assumptions used in developing the models.
- A description of the Nursing Models.

Divisions of General Practice can utilise the information provided in this package when discussing the benefits and implications of employing a practice nurse with those practices that have yet to employ a nurse, and with those interested practices that already have a nurse/s and would like further information on possible roles for the practice nurse/s.

It is envisaged that practices interested in the package would receive the sections relevant to their practice. For example:

- Each practice would receive a copy of the information sheet outlining the methodology and assumptions used.
- A large urban practice would receive the large urban financial model and a copy of the case studies relevant to that practice.

Disclaimer

Please be advised that the information provided in this package is intended as a guide only and reflects funding arrangements prior to the introduction of Strengthening Medicare. It is acknowledged that general practices are private businesses and that methods of operation will vary from practice to practice. The information is intended to give some baseline information to support general practice in the decisions about employing and utilising a practice nurse.

The Australian Divisions of General Practice Ltd and the Commonwealth will not be liable for any loss sustained by medical practitioners or practices as a result of adoption of the supplied models or from changes to the programs or services upon which they rely. General practitioners and practices should check current Medicare Benefits Schedule requirements before making any decisions in relation to employing or utilising the services of a practice nurse.

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 North Queensland Rural Division of General Practice
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 Royal College of Nursing Australia
 Southern Division of General Practice (Adelaide)
 Southern Tasmania Division of General Practice
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PROJECT OVERVIEW

FIRST PHASE:

- ADGP appointed Kristine Battye Consulting to prepare the Business Case Models. Confirmation and clarification of the project plan was undertaken between ADGP, the project consultant and DoHA.
- The Scoping Workshop:
 - This workshop was held in November 2002 and attended by ADGP, DoHA and Division representatives. The aims of the workshop were to enable participating Divisions to present their existing business cases supporting the role out of the Nursing in General Practice Budget Initiative; and to enable ADGP to assess the common features to inform the development of the draft business cases.
- Literature search, industry scoping exercise and desktop analysis:
 - A broad range of materials was assembled from a variety of sources including Divisions, nursing organisations and recent research projects. Analysis of these resources informed the second phase of the project. To develop the financial structure of the business cases, the consultant used several significant practice costs benchmarking studies and validated these against actual practice costs determined during the site visits. The benchmarking studies used included the: Relatives Values Study, RACGP Inter-Practice Comparison Survey and the most recent report from CCH Benchmarking.

SECOND PHASE:

- Site visits to selected Divisions and General Practices:
 - Visits to six Divisions of General Practice commenced in December 2002 and concluded in February 2003.
 - Divisional staff arranged a selection of practices for visits within each Division. The site-visits to Divisions of General Practice and to general practices had two important functions. Firstly, the visits were a critical information gathering process, collecting data at the Divisional and practice level. The Divisions were able to provide important information on their role in supporting practice nurses and the barriers and enablers they had encountered, while practices, which included GPs, managers and nurses, provided a large amount of background information on barriers, roles, finances and support needs. The second key function of the visits was as a validation exercise, whereby the methodology, underlying study assumptions, practice, and nursing models were tested across a range of environments and with a range of stakeholders.
- Development of draft business cases:
 - This was undertaken using information gained from the resource analysis process and input from the site visits.
 - An economic analyst was involved in the project providing assistance and advice on the transferability and sustainability of the business case models.

PROJECT OVERVIEW cont.

- Presentation to Project Working Group:
 - This took place in February 2003 with the preliminary results from the site visits tabled and discussed.
 - The working group further developed the proposed structure and contents of the business cases, the options for distribution and dissemination of the finished business cases.

THIRD PHASE:

- The Validation workshop
 - Held in March 2003 with ADGP, DoHA, Division, and SBO representatives.
 - The workshop comprised a detailed presentation by the consultant of the draft business cases, rationale, support materials and proposed dissemination strategy.
 - The project rationale and the final draft business cases, support materials and dissemination strategy were discussed in detail and feedback sought from participants.
- Presentation to the National Steering Committee on Nursing in General Practice in March 2003.
 - The project rationale and the final draft business cases, support materials and dissemination strategy were discussed in detail and a number of further revisions requested.
 - Presentation of the final report to DoHA in May 2003. Since this time, the Business Cases have undergone several revisions undertaken by ADGP at the request of the Department of Health and Ageing.

METHODOLOGY

This study has used modelling to create artificial but realistic general practice scenarios that allow the modeller to suggest ways in which introducing nurses into general practices *may* affect the financial performance of that practice.

To ensure that the models developed are appropriate and approximate 'normal' general practice in Australia, the study has utilised benchmark data on the finances of general practice. Where the description of the practice specifies a cost factor (such as the exact number of staff employed) this has been calculated directly and explained in the model. Where a more general factor is introduced (such as rent or cleaning costs), benchmark data is used. Benchmarks are also used to compare cumulative data (such as total practice costs) with the actual models, to determine how *realistic* or *robust* the models are.

No two practices are alike and so no model will ever *exactly* represent any individual *real* practice. The purpose of the models is to represent *typical* practices to which most (but not all) other practices can be compared. The reader will have to determine whether the models actually compare to the reader's practice and if not, then in what ways the two differ.

The purpose of this section is to clarify the origin and make-up of the benchmark data used, so that more detailed comparison between the benchmarks, the model practice and the reader's own practice can be undertaken.

The benchmark data used in this study was developed from a number of sources, including the *Relative Values Study* (Price Waterhouse Coopers), the *Inter-Practice Comparison Survey* (RACGP) and other commercial and private data providers. This data was standardised to 2003 prices and then averaged to produce a *mean* result for each item. This mean result is used in this study.

INCOME:

For this modelling exercise, income is simplified to include fee-for-service income and PIP lump sum payments only. Individual practices may have sub-tenancies (pharmacies, allied health, pathology collecting rooms etc), service contracts (private companies, government departments), medico-legal contracts (as expert witnesses) etc. Each individual practice will have to consider their own practice circumstances when comparing their practice to the model described.

Benchmarks for fee-for-service and PIP income are obtained from benchmarking studies as described above and from HIC data available from the HIC website at www.hic.gov.au.

COSTS:

Costs are divided into three principal components for the purpose of this study: -

- Practice staff costs,
- Practice non-staff costs, and
- Professional costs

METHODOLOGY cont.

Practice staff costs

The benchmark data provides useful information on average staffing levels for the three sizes of practice in the modelling exercise. Combining these with current award wages for the levels of staff indicated, provides a benchmark level for the staff costs component of the study. A number of associated costs are factored into this level including: - annual leave, superannuation, long service leave, workers compensation insurance and training. The benchmark studies did not identify a significant difference in the staffing levels of urban and rural practices, of comparable sizes.

The benchmark staffing levels of the three practice sizes was as follows: -

Model	Total staff	Clerical	Management	Nursing
Solo	1.4	1.0	0.2	0.2
2 GP	2.7	1.9	0.4	0.4
5 GP	6.3	4.3	1.0	1.0

The models use the 2003 benchmark wage levels being: -

- Clerical - \$28,000 pa plus 20% on-costs = \$33,600 pa
- Practice Management - \$35,000 pa plus 20% on-costs = \$42,000 pa
- Practice Nursing - \$42,000 pa plus 20% on-costs = \$50,400 pa

Thus for the models, the benchmark staffing costs were determined as:

Model	Total staff costs	Clerical staff costs	Management staff costs	Nursing staff costs
Solo	\$52,080	\$33,600	\$8,400	\$10,080
2 GP	\$100,800	\$63,840	\$16,800	\$20,160
5 GP	\$236,880	\$144,480	\$42,000	\$50,400

For each of the models, the baseline staffing costs will be lower than the benchmark levels, as the baseline models all assume *no* nursing component to the staffing levels. Each of the models then has each of the three models of practice nurse utilisation applied to it and the financial implications explored.

Practice non-staff costs

This section includes all costs to the practice, which are not direct staff costs and which are not specifically attributable to the individual medical practitioners (which are separated out as *professional costs*). Practice non-staff costs will generally decrease relatively as the number of practitioners increases (economies of scale), whereas professional costs will increase proportionally with the number of practitioners. Some non-staff costs are likely to be lower in rural areas (rent, insurance etc), while some may be higher (repairs, telephone and computer costs etc). These differences are reflected in the benchmarks. Practice non-staff costs can be broken down into several categories, as follows: -

- *Occupancy costs*: - Rent, security, cleaning, laundry, waste disposal, electricity and gas, contents and public liability insurance, plant and equipment and magazines.
- *Office expenses*: - Accounting and professional fees, advertising and promotion, bank charges, computer consumables, postage, printing and stationary, repairs and maintenance, telephone and communication and sundry expenses

METHODOLOGY cont.

- *Accreditation costs:* - This component includes \$1,000 per GP over 3 years for survey expenses and \$700 per year for education, training and compliance costs. Allowance is made within staffing levels for some additional time to be allocated from nursing and management staff for this purpose.
- *Other practice costs:* - Medical supplies, depreciation and bad debts
- *Working capital:* - This denotes the opportunity cost of capital invested in plant, equipment, stock and cash flow requirements in the practice and is based on *best alternative use* principles – in this case – fixed interest deposits.

For the models developed, the benchmark practice non-staff costs were determined to be: -

Model	Total costs	Occupancy costs	Accreditation costs	Office costs	Other costs	Working capital costs
Rural						
Solo	\$60,800	\$24,300	\$1,000	\$16,700	\$11,700	\$7,100
2 GP	\$105,700	\$39,200	\$2,000	\$33,400	\$18,800	\$12,300
5 GP	\$234,800	\$77,300	\$5,000	\$83,500	\$40,700	\$28,300
Urban						
Solo	\$62,800	\$27,300	\$1,000	\$15,700	\$11,700	\$7,100
2 GP	\$109,700	\$45,200	\$2,000	\$31,400	\$18,800	\$12,300
5 GP	\$245,300	\$92,300	\$5,000	\$79,000	\$40,700	\$28,300

Professional costs

This section includes all costs specifically attributed to the GP and includes: -

- *Motor vehicle expenses:* - Where related to practice business. The additional distances travelled by rural GPs because of the dispersed nature of the communities they serve, are deemed to balance the higher costs of parking and garaging of vehicles in urban areas.
- *Professional indemnity insurance:* - This will depend on the procedural or non-procedural status of the GP, which is stated in the practice description. The insurance quotes received at April 2003 suggest that full-time GPs at level 1 rates (non-procedural), pay approximately \$3,500 per annum, while basic level procedural GPs (no obstetrics and no anaesthetics) pay approximately \$5,000 per annum.
- *Professional memberships / registrations:* - For the purposes of this modelling exercise, it is assumed that all GPs are financial members of the RACGP. It is acknowledged that some rural GPs may be members of the RDAA or ACCRM; and GPs may be members of the AMA or other organisations, however this is not taken into account in this modelling exercise. It is also assumed for this exercise that membership of the local Division is either free or carries a minimal charge. Medical registration costs are estimated at \$300 per annum.

METHODOLOGY cont.

- *Locum costs:* - For the solo and 2-GP practices, this expense is deemed to be the salary paid to a locum GP for the 6 or 12 weeks of the year for which they are required. As no income is assumed from these locums (income assumes each GP works for 46 weeks per year), the expenses of employing them is equated with the income they generate and no final entry is required (income generated equals expense of employment). The enormous range of practice locations and needs mean that this component of the model cost structure will be contentious and each reader is advised to review this section in terms of their own practice experience. The five GP practices are assumed to provide internal cover for the absence of their colleagues and therefore no locum fees are required.
- *Deputising expenses:* - The rural practices provide collaborative after-hours care and receive a higher level of PIP payment as a result. The urban practices employ a locum agency and a figure is added to costs for the enrolment in this service.
- *Education expenses:* - This will vary enormously between GPs, according to individual educational needs and wants and costs of accessing appropriate venues / events. Using the excellent methodology developed for the *Relative Values Study* standardised to 2003 prices, this equates to \$2,900 per annum per GP.

There were some significant differences between the models because of the high cost of procedural GP indemnity insurance and the relatively higher cost of locum cover / arrangements in rural areas as opposed to urban general practice.

The benchmark professional costs were determined to be: -

Model	Total costs	Vehicle costs	Indemnity insurance	Professional memberships	Deputising costs	Education costs
Solo - rural	\$20,050	\$9,950	\$5,000	\$1,100	\$1,100	\$2,900
2 GP – rural	\$40,100	\$19,900	\$10,000	\$2,200	\$2,200	\$5,800
5 GP – rural	\$100,250	\$49,750	\$25,000	\$5,500	\$5,500	\$14,500
Solo – urban	\$18,550	\$9,950	\$3,500	\$1,100	\$1,100	\$2,900
2 GP – urban	\$37,100	\$19,900	\$7,000	\$2,200	\$2,200	\$5,800
5 GP - urban	\$92,750	\$49,750	\$17,500	\$5,500	\$5,500	\$14,500

ASSUMPTIONS USED IN DEVELOPING THE MODELS

The models were developed using the above methodology and based on the information provided by the general practitioners and practice staff that participated in the study. The information was validated as outlined in the Third Phase of the project as described on page 4. A number of assumptions have been used in developing in the models based on the information provided. The methodology and assumptions are explained in italics through out the models. Practices using this information should check the Medicare Benefits Schedule requirements before following the advice in the Business Case Models and apply the model to their own practice situation.

Many of the models describe practice nurse involvement with home health assessments reflecting in some cases an estimated practice uptake of up to 90%. This is well above the level reported in the recent Review of Government Services Report that reflects a national estimated uptake of around 17% of eligible patients.

Practices involved in the study reported that having a practice nurse involved in health assessments increased the uptake well beyond the national level, however this information should be used with caution and practices considering the adoption of the model should apply the model to their own situation.



ASSUMPTIONS USED IN DEVELOPING THE MODELS cont.

Practices involved in the study reported that the practice nurse component of the home health assessment took on average a period of one hour to complete. Some of the models reflect practice nurses undertaking six health assessments within an eight-hour period, with some time allowance for travelling and staff breaks. Once again this information needs to be used with caution, as the time taken for a nurse to conduct a health assessment will vary according to the skills and experience of the nurse and the complexity of the case. It is also acknowledged that travel time may be significant particularly in rural areas.

The information contained in the documents is intended to give some baseline information to support general practice in decisions about employing and utilising a practice nurse. General practitioners and practices should check current Medicare Benefits Schedule requirements before making any decisions in relation to employing or utilising the services of a practice nurse.

THE NURSING MODELS

The development of the models was undertaken through a detailed process of review and industry scoping, which included site visits to a number of Divisions and general practices. The result of this process was the description of four general categories for the role of practice nurse, which were defined as:

1. The *clinical support role*, which involved the undertaking of clinical duties as the delegate of the GP, with the purpose of liberating GP time. Examples of duties under this role were: - Wound care; Immunisations; Cardiograms; Spirometry, etc
2. The *administrative / management role*, which involved managing clinical systems, recall and reminders systems, stock control, equipment maintenance, infection control, sterilisation and accreditation
3. The *EPC / PIP role* which ranged from providing home health assessments to managing the EPC system with patient audit and recruitment, recall registers, diabetic registers, assisting with patient education.
4. The *enhanced or primary care role*, which saw some Practice Nurses running 'clinics' for things such as: - weight loss, women's health, incontinence, diabetes, asthma, antenatal care and well baby checks.

These roles are not models, but provide the underlying understanding of the nurse roles that enabled the modeller to describe three distinct models for the use of Practice Nurses, that roughly represented the real job descriptions of the majority of Practice Nurses contacted during the study. These models, which are described below, have proved robust and were strongly supported by the Validation Workshop participants and the nursing representatives on the National Steering Committee for Nursing in General Practice.

THE NURSING MODELS cont.

THE SPECIAL SESSION MODEL:

In this model, the practice 'buys in' (through community health or other local agencies / Divisions of General Practice) a diabetes nurse educator, an asthma nurse educator or an EPC specific nurse for a variable number of four-hour sessions (three per fortnight in the small practice models and six per fortnight in the large practice models). This allows a limited access to chronic disease initiative and EPC payments but the nurse does not have a role in the general running of the practice. The nurse sees up to two patients per hour during the four-hour sessions and the GPs see each patient for 20 minutes at the end to review the findings. These sessions increase practice access to chronic disease initiative payments but do not include sufficient hours to qualify the practice for the special nurse initiative payments.

THE GENERALIST PRACTICE NURSE MODEL:

In this model, the practice employs the practice nurse for the necessary number of sessions per week to maximise access to the PIP incentive. The nurse has a clinical support role, undertaking tasks delegated by the GPs (such as dressings, ECGs, immunisations, spirometry). In free time (if any) the nurse begins a file audit to identify >75 year olds for home based health assessments (which she then performs twice a week), and diabetics to create a register and undertake a clinical audit and begin to access chronic disease initiative payments. In the urban practices the PIP is not available to fund practice nurses but this 'middle-range' model still seems to fit the actual nurse roles observed, better than the other two models described in this section.*

THE ADVANCED PRACTICE NURSE MODEL:

In this model, the nurse is employed for more hours than the PIP nurse incentive payments require and operates half-day clinics in diabetes, asthma, woman's health (including Pap smears, breast checks and family planning advice) and health promotion including smoking cessation and weight loss. The nursing role would probably be split between two or more part-time nurses to allow the range of skills / qualifications and to ensure backfill cover for annual, sick and study leave. In this model, the nurse manages the EPC program and identifies patients that would benefit from a care plan. The nurse may have postgraduate training in woman's health or be a qualified Diabetes Nurse Educator or Asthma Nurse Educator. The nurse requires regular release for educational updates and training courses. This model involves a significant amount of GP time involved in undertaking care plans. It is provided as a good quality example of team-based management of a patient's complex care needs *

**These models were developed before the introduction of the Strengthening Medicare Package. Since these models were developed some practices in urban areas of workforce shortage have become eligible for the practice nurse incentive payment; and all practices where medical practitioners are eligible to receive Medicare benefits have become eligible to claim two new MBS items for services provided by a practice nurse on behalf of the medical practitioner for immunisation and wound care. These changes are not reflected in the business models.*

CONCLUDING REMARKS

The examples used in these models indicate that it is financially viable for a practice to employ a practice nurse, and some of the models demonstrate that having a nurse available at the practice can significantly add to practice income. Apart from the financial aspects, the practices interviewed for this study indicated that there is a range of benefits to having a nurse employed by or contracted to the practice. These benefits are highlighted in the case studies and include:

- Improved work satisfaction for the GP/s.
- Additional support for the GP/s.
- Reduction in patient waiting times.
- Increased range of services offered at the practice.
- Increased capacity to adapt to change.
- Improved management of patients with chronic disease.
- Improvements in quality of care to patients.
- Increased consumer satisfaction.
- Additional inducement to recruit new GPs.

List of Abbreviations

ACRRM	Australian College of Rural and Remote Medicine
ADGP	Australian Divisions of General Practice Ltd
AMA	Australian Medical Association
Division	Division of General Practice
DoHA	Australian Government Department of Health & Ageing
DVA	Australian Government Department of Veterans' Affairs
ECG	Electro Cardiogram
EPC	Enhanced Primary Care
FTE	Full time equivalent
GP	General Practitioner
GPA	GPA Accreditation <i>plus</i>
HIC	Health Insurance Commission
ICU	Intensive Care Unit
MBS	Medicare Benefits Schedule
NSC	National Steering Committee for Nursing in General Practice
PIP	Practice Incentives Payment
PM	Practice Manager
PN	Practice Nurse
RACGP	Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RRMA	Rural, Remote and Metropolitan Area
RVS	Relative Values Study
SBO	State Based Organisation of Divisions of General Practice
SIP	Service Incentive Payment
SWPE	Standardised Whole Patient Equivalent