Nursing in General Practice Business Case Study
Rural Case Studies

NURSING IN GENERAL PRACTICE CASE STUDY # 8

Size:	**Small**	*Location:*	**Rural**
FTE GPs:	1.0	*FTE Practice Nurses:*	0.6
SWPEs:	1,400	*FTE Other Staff:*	1.5

The study practice is a three-year-old, purpose built solo practice in a town of 5,000, which has 4 GPs. The practice is fully accredited, computerised (although medical records are still paper based) and has had a Practice Nurse since opening its doors. Initially the nurse was employed for only 1-2 sessions per week, but this has now built up to 6 sessions. The practice operates 8.30am to 6.00pm weekdays and 8.30am to 12.00pm Saturday. The practice is private billing with a standard fee of $40 (about 30% of patients), bulk-bills few patients (about 10% - mainly DVA) and charges a discount fee of $35 to concession card holders (about 60%).

The practice nurse hours are 9-1 every week day and 2-6 one afternoon. The practice funded the nurses to attend a certified family planning course at a cost of about $2,000 and the nurse is now able to run a 'Well-Woman clinic' one afternoon per week - performing Pap smears, breast checks, and providing contraception advice and sexual health counselling. The nurse has a normal clinical workload of ECGs, spirometry, surgical assisting etc and has been developing all the practice clinical administrative systems 'from scratch' such as procedures and protocols. She also managed the accreditation process.

The practice has not embraced the new chronic disease PIP items as the GP was worried that the recalling and frequent visiting would increase pressure to bulk-bill patients, which could be the 'thin end of the wedge'.

The practice provides 60 to 70 patient consultations per day and the GP estimated that they were able to see '5 or 6' more patients per day than if a nurse was not employed – worth $175 per day or $45,000 per year. The PN also increased the PIP by about $11,000 per year and helped access EPC. Thus the PN was valued in excess of $55,000 per year at a cost of about $35,000 for the hours worked.

The GP felt that employing the practice nurse was essential to the practice from both a clinical and financial perspective. Having a practice nurse that was experienced / skilled and prepared to undertake training in areas where additional skills were required was vital. Recruiting a suitable nurse had not proved difficult but the GP thought that this may be the case in many rural communities.

NURSING IN GENERAL PRACTICE CASE STUDY # 9

Size:	**Large**	*Location:*	**Rural**
FTE GPs:	3.0	*FTE Practice Nurses:*	0.6
SWPEs:	3,000	*FTE Other Staff:*	2.0

The study practice is a three-doctor group (3.0 FTE) in large rural town. The practice is long established, fully accredited, computerised (but not paperless) and performs all its own after-hours cover. The practice operates 8.30am to 5.00pm weekdays and 8.30am to 12.00pm Saturday. The practice is private billing with a standard fee of $39, bulk-bills few patients and charges a discount fee of $34 to aged pensioners only.

The practice employs one nurse for 22 hours per week – the minimum amount required to obtain the maximum PIP available. Prior to this appointment, the main receptionist had been a nurse and had undertaken some clinical duties when needed, such as ECGs, dressings and vaccinations. The Practice Nurse was appointed 12 months ago and came with 16 years experience. The administrative component of her responsibilities is large and includes infection control, cleaning/disinfecting, infectious waste disposal, stock balance and ordering, vaccination program, vaccine ordering and storage, monitoring vaccine fridge, sterilization, clinical equipment maintenance and accreditation. Her clinical duties are managed by an appointment diary, which is on the same system as the GPs appointments. She books 4 patients per hour for ECGs, dressings, spirometry, ear syringing and injections. The practice nurse also has developed a primary health care role and runs a weight reduction program, immunisation program, blood pressure and respiratory function checks. The nurse has no direct role in EPC item use as yet. Home Health Assessments are undertaken by two other nurses attached to the practice (each nurse is the wife of a GP at the practice).

The practice estimates that having the nurse has saved them about 5 minutes per hour of GP consultation time. The nurse was now seeing 15 patients per day while the GPs were still seeing the same number they had booked before, thus the practice is billing 15 more patients per day, increasing gross revenue by about $100,000 per year. The PIP nurse incentive is worth about $24,000 per year for this practice. There may well be other benefits yet to be accessed including greater EPC item number use through involving the nurse in administrative and clinical support for care plans. The cost of the nurse is 0.6 x $35,000 or about $22,000 per annum. No new facilities and minimal equipment were required. One additional computer station at about $5,000 including software licences was purchased. Minimal IT training was required as the nurse was already well trained. The practice nurse has therefore added about $95,000 per annum to net practice income.

Having a practice nurse that was experienced was very important, as she had to 'create' her role when she started, as there was no clinical precedent. The availability of the PIP nurse incentive was the trigger that made the practice decide to employ a nurse but now that they have they would continue in the absence of the incentive as the financial and patient benefits have become apparent.

The practice nurse role has achieved in-house provision of services previously not provided due to lack of time and skill. Most dressings used to be referred to the hospital dressings clinic, while ECGs and spirometry were just not done. Patients were referred for dietetic advice if they needed weight reduction programs. Now all of these services are provided in-house. This has increased the quality and comprehensiveness of services provided to the practice patients and maintained input and some control by the GPs.

NURSING IN GENERAL PRACTICE CASE STUDY # 10

Size:	**Large**	*Location:*	**Rural**
FTE GPs:	3.0	*FTE Practice Nurses:*	0.6
SWPEs:	2,200	*FTE Other Staff:*	3.0

The study practice is a three-doctor group (one of which is a GP registrar) in a small rural town of about 7,000 with six GPs. The practice is fully accredited, fully computerised and has had a practice nurse since 1990. The practice operates 8.30am to 5.30pm weekdays and 8.30am to 12.30pm Saturday. The practice is private billing with a standard fee of $42, bulk-bills about 20% of patients and charges a discount fee of $36 to another 30%.

The part-time practice manager was formerly the practice nurse, however the existing practice nurse has been in the practice for about 3 years, and works 5 hours every weekday. The Practice Nurse position has always been for 5 hours every weekday. The Practice Nurse is a registered nurse and midwife and has immunisation accreditation. She is going to do an accredited family planning course this year so that she can start doing Pap smears, breast checks etc. She already runs antenatal, post-natal and breastfeeding clinics. Nursing duties are dominated by the administrative role which includes: - infection control, cleaning/disinfecting, infectious waste disposal, stock balance and ordering, vaccination program, vaccine ordering and storage, monitoring vaccine fridge, sterilization, clinical equipment maintenance and accreditation. Clinical workload is managed through an appointment diary as for the GPs, booking 4 – 5 patients per hour including ECGs, dressings, spirometry, ear syringing and injections. There is an expanding primary health care role, which includes antenatal checks, post-natal checks, breastfeeding support and vaccinations and soon will also include Pap smears and breast checks.

The practice estimates that having the nurse saves about 4 minutes per hour of consultation time, based on the nurse seeing about 10 patients per day who would otherwise have been shared between the three GPs. The practice provides 100 GP contact hours per week therefore the nurse 'saves' 400 minutes of this time. Assuming 15 minutes per consultation, this equates to 26 additional consultations per week, at an average of $36. This equates to $936 per week or $47,000 per year. In addition the practice receives about $18,000 of Practice Nurse PIP, giving a total benefit of about $65,000. The Practice Nurse wages, including on-costs are about $35,000 and there are no other significant facility, equipment or training costs. Thus the practice benefits by about $65,000 per annum for a cost of about $35,000, leaving a comfortable margin of $30,000. Even in the absence of the government initiatives, the practice nurse would easily cover her costs through increased GP time efficiency.

The practice felt that a key requirement was for the nurse to have good communication and teamwork skills. The relationship between the PN and the reception / secretarial staff is important for practice harmony and delegation of duties. If the practice were to increase nursing hours, they would probably get a second nurse rather than increase the hours of the existing nurse, so that it would be easier to organise cover for periods of leave.

NURSING IN GENERAL PRACTICE CASE STUDY # 11

Size:	**Small**	*Location:*	**Rural**
FTE GPs:	1.0	*FTE Practice Nurses:*	1.0
SWPEs:	800	*FTE Other Staff:*	1.0

The study practice is a solo rural practice in a town of 850. The principal GP works 8 sessions per week and a GP from a nearby town works 2 sessions per week to provide some relief. The practice is very new – it was set up in the public health clinic by the local community, which also recruited the GP and is in the process of building a brand new, stand alone clinic for the GP. The practice opens 9.00 to 5.00, Monday to Friday and sees about 40 patients per day. After-hours care is managed by a telephone triage system operated by the local Division of General Practice. All patients are bulk-billed with an average fee per patient of about $30, providing a weekly fee-for-service income of around $6,000. The practice is not yet accredited but when this is achieved, the PIP will add about $24,000 per year including $7,000 for the nurse incentive.

The practice nurse has been employed for nine months and has had a very high administrative workload, developing and implementing clinical management systems with a particular view to rapid achievement of accreditation. Although the clinical component of her work to date has been limited to direct GP support, she is a highly qualified and experienced practice nurse with Women's Health and Immunisation certificates. The administrative burden on the nurse is higher because the only clerical staff member is very inexperienced. Once the initial set-up of systems is completed, the nurse will use the available time to initiate primary health care in the community, with chronic disease management, home based care and preventative care / health promotion roles, including school visits.

The GP estimated that having the nurse available increased the work capacity from 30 to 40 patients per day, thus generating another $300 per day in fees. The GP still sees the 40 patients however the effect of the nurse is to reduce the amount of time the GP needs to spend with some patients, thereby increasing capacity without extending working hours. In terms of retention / burnout prevention, this is a critical role. In addition to the $300 per day mentioned above, the GP estimates that EPC and SIP access, when time allows, will add $200 to $400 per week to income.

This is not a profit driven practice. The GP has made lifestyle choice in keeping working hours to 32 per week and the employment of the practice nurse is a choice based on quality of patient care rather than economic reasons. However, it should be noted that, even given the mainly administrative role of the nurse in this practice, her clinical role still generates more money (as shown above) than she costs to employ.

NURSING IN GENERAL PRACTICE CASE STUDY # 12

Size:	**Small**	*Location:*	**Rural**
FTE GPs:	2.0	*FTE Practice Nurses:*	0.0
SWPEs:	2,200	*FTE Other Staff:*	2.0

The study practice is a two GP practice in a new, purpose built facility and is the only practice in a small rural town of 2,500 persons. After the old practice closed and two years passed with no GP in the town, a community action group built the new facility and recruited the two GPs. The practice opens 9.00 to 5.00 weekdays and 9.00 to 12.00 Saturday. After-hours calls are diverted to the Division telephone nurse triage system, which minimises call-outs. Fee for service is about 50% bulk-billing with an average fee of about $35 and weekly income around $11,000 plus PIP of about $60,000, which doesn't include the nurse incentive.

There is no practice nurse although the GPs have been actively considering employing one and have been in contact with the Division of General Practice to discuss this. The Practice Manager is non-clinical but highly skilled and hard working and apart from managing the administrative part of the practice, supports the GPs in their management of the clinical side of the practice. The PM manages stock and equipment. Sterilisation of equipment.is performed 'off-site' and infection control is managed, in theory, by the GPs. The GPs undertake all procedural work that is required – vaccinations, Women's Health, dressings etc. The practice has been attracted to employing a nurse, mainly by the financial incentive (as they would qualify for more than $16,000 per annum) but are put off as they would have to employ the nurse for at least four sessions and cannot imagine what the nurse could do in all that time! Both the GPs and the PM were very interested to find out what nurses were doing in other practices.

The GP is planning to access the Divisional Diabetes Nurse Educator for 2 sessions per week and is negotiating space and support requirements for this person with the Division. The GP felt that this would be a good introduction to having a nurse in the practice and could lead to more hours being utilised. The GP commented that many of the proposed roles of the practice nurse (asthma educator, diabetes educator, lactation consultant etc) were being undertaken at the local Community Health facility but that he had great difficulty finding out whether his patients were attending and what they were being told. He could see that having a practice nurse, at least to co-ordinate activities with Community Health, would greatly improve patient management from a practice perspective.

The Division and GP have estimated that a practice nurse could raise the billing of the practice from $11,000 per week to $14,000 per week with greater clinical efficiency, more use of practice equipment, EPC and SIP access and more 'in-house' care of patients. When added to the additional PIP available, the financial advantages to the practice were potentially very significant.

Despite very strong evidence of economic and patient advantages and good support from the local Division, this practice has still not employed a practice nurse, largely because of administrative reasons. The GPs can see the advantage of the nurse but neither is driving the process of employing the nurse. The Practice Manager would be the person to drive the process but may have some misgivings about taking on a staff member that she may perceive could reduce her own role or be in competition. It seems inevitable that this practice will take on a nurse at some stage, possibly through sessional employment of specialised nurses as currently being arranged by the Division. This is however a very good example of how economic reasons are not always the main barriers to practices taking on nursing staff.