Nursing in General Practice Business Case Study
Metropolitan Case Studies

NURSING IN GENERAL PRACTICE CASE STUDY # 1

Size:	**Small**	*Location:*	**Metropolitan**
FTE GPs:	1.0	*FTE Practice Nurses:*	1.4
SWPEs:	1,200	*FTE Other Staff:*	1.5

The study practice is a solo GP on the fringe of a large provincial city. The practice was set up three years ago and is paperless. There are ten GPs in the region who share an after-hours roster. The practice operates 9.30am to 6.30pm five days. The practice is private billing with a standard fee of $43, bulk-bills very few patients (vaccinations, second patient in the consultation etc) but charges a discount fee ($31) to pensioners and 'hardship' cases. Overall about 60% of patients pay full fees.

The GP employs 3 practice nurses who provide a total of seven whole day equivalents of nursing cover between them (1.4 FTE). All the nurses have undertaken post graduate training in family planning and perform Pap smears, breast checks and provide contraception advice as well as the normal range of clinical duties including: - preparation for diving / insurance medicals, audiograms, spirometry, ECGs, surgical assisting etc. The practice is set up with three fully equipped consulting rooms. In this practice both the GP and nurses run appointment books with triage of patients by the 'team leader' (see below) according to a protocol. Both the GP and the nurse book 20-minute concurrent appointments. The GP spending 15 minutes with their patient and then 5 minutes with the nurse's patient to answer questions and provide prescriptions etc. During this five minutes the nurse can perform any necessary duties on the GP's patient such as injections, dressings etc. Thus while each books only 3 patients per hour, the GP is able to service 6 patients per hour of which, on average, 4 pay full fees, 1 a discount fee and 1 is bulk-billed.

A mental health nurse has recently been employed 4 to 6 hours per week and provides grief counselling and psychosocial support to two patients per hour, using the same GP supervision system as the main clinic nurse, with the GP reviewing each patient.

The practice also employs 1.5 secretarial staff who, with the nurses triage the patients to either the GP or nurse and manage the administration of the practice. The nurses cost about $30 per hour including on-costs and the secretaries about $20. One staff member is the designated 'team leader' for each day. An emphasis in the practice is on reducing time wastage and with this in mind, much thought has gone into role definitions of staff, set up of facilities and equipment, use of computer technology including shortcuts in the software etc.

The GP attends a large local retirement village two mornings per week during which time the nurse(s) perform home health assessments. After the medical component is performed and the health assessment discussed, the GP may instigate a care plan if required and the nurse will assist with the administrative and clinical support components.

The practice bills approximately $10,000 per week. Being a solo, non-rural GP, the PIP component of income is quite low. The staff costs are high at about $3,000 per week – being $1,750 for nurses and $1,250 for secretaries. This high staffing level does however significantly increase the productivity of the doctor well above normal levels for a solo GP. Using the RVS and other benchmarking studies, the annual overheads for this practice can be estimated at $70,000 - $90,000 ex staffing costs. Thus, allowing 8 weeks per year of neutral trading (locums, holidays etc) annual net income is potentially $180,000 - $220,000. The practice has been accredited through GPA. The GP is very happy with both the clinical and financial performance of the practice and is confident of high-level patient satisfaction being booked well in advance and having 'closed books' to new patients. Even in the absence of the 'nurse friendly' financial opportunities available (EPC, PIP/SIP etc) the GP would not change the model of practice and continues to look for ways of expanding the nurse role within the practice.

NURSING IN GENERAL PRACTICE CASE STUDY # 2

Size:	**Large**	*Location:*	**Metropolitan**
FTE GPs:	5.0	*FTE Practice Nurses:*	1.0
SWPEs:	8,800	*FTE Other Staff:*	6.0

This is a large bulk billing, corporate owned medical centre in a provincial city. The practice has been operating for about 12 months, is paperless, is not accredited and PIP access is not an important part of the business plan. The philosophy of the practice is to provide access to medical services rather than continuity of care and therefore operates in a paradigm closer to a hospital emergency department than a traditional general practice.

The practice operates from 7.00am to 11.00pm every day of the year and employs 5 GPs, who work long hours and see high volumes of patients. Patients are encouraged to make appointments but more than 80% of patients seen, arrive without an appointment. Most patients are bulk-billed to Medicare although 10 to 20% are overseas travellers, workers compensation, diving medicals or similar non-Medicare rebatable patients. The practice is staffed each weekday by 3 or 4 of the GPs with 2 to 3 working each weekend day and public holiday. The GPs generally see 70 to 75 patients per day at between 6 and 10 patients per hour, stopping work when they approach the 80 limit under the Medicare 80 / 20 rule that limits excessive servicing.

The practice employs a single practice nurse to provide clinical support to GPs, infection control/sterilisation, stock and equipment management and immunisation services. The Practice Nurse is employed from 9.00am to 5.00pm on weekdays only, which is less than half of the operating hours of the facility. The nurse is an experienced RN who finds the role challenging but rewarding. The most important function of the nurse within the practice is to ensure a smooth throughput of patients and to minimise the time that the GPs have to spend undertaking procedures during normal working hours. The practice provides a large number of pre-employment, insurance and diving medicals with patients having considerable 'work-up' performed prior to the GP consultation. This work up includes completion of a history questionnaire as well as spirometry, audiometry, tympanometry and ECG if indicated.

GPs state that the nurse saves them a large amount of time which is difficult to quantify, but that there was no overall financial benefit as they simply would take a little longer to reach their patient number limit for the day if the nurse was not available. However, they conceded that the work of the nurse made their job much easier and more pleasant and also helped to minimise congestion and prevent a blow out in patient waiting times.

The cost of employing a practice nurse in this facility is about $40,000 per year including on-costs, which as a proportion of total revenue of about $3M per year is almost inconsequential. The reason for employing the practice nurse is to ensure that infection control duties are performed by a qualified person (sterilisation etc) and to provide support to the GPs particularly at times of high workload. The business plan clearly identifies the need for at least 3 GPs to be working to justify the cost of a PN hence the limited nursing hours.

The PN in this type of practice needs to be very clinically experienced particularly in emergency care and triage. The Primary Health Care role of the traditional Practice Nurse is lost in this form of practice, as it does not fit well with the central paradigm being the generation of profit. While this form of practice certainly fulfils a role in providing access to health care for the disadvantaged or those that work anti-social hours and in reducing the demand on public hospital emergency departments, it is not a general practice in the broadly defined sense (hence the difficulty achieving accreditation) and is not a good environment for the development of the enhanced role of the Practice Nurse.

NURSING IN GENERAL PRACTICE CASE STUDY # 3

Size:	**Large**	*Location:*	**Metropolitan**
FTE GPs:	5.5	*FTE Practice Nurses:*	2.0
SWPEs:	5,600	*FTE Other Staff:*	5.0

The study practice is a large private-billing group general practice in a provincial city, part owned by a corporate entity but with significant shareholding by 3 of the 8 GPs that work in the practice. The practice is long established but has been under part corporate ownership for 6 years. The practice is fully computerised and fully accredited. The practice operates 7.00am to 6.00pm weekdays and 8.00am to 1.00pm Saturday. The GPs provide a broad range of styles of practice and most patients see one regular GP. The private fee is $40 (about 30% of patients) with a discount rate of $30 for cardholders, children etc.

The practice provides at least one nurse for all hours the facility is open, with two available at busy times (about 20 hours of overlap per week). The nurses undertake a broad range of roles including: ear syringing, plastering, dressings, injections, immunisations, ECGs, audiometry, spirometry and assistance with surgical procedures. Approximately half of the Practice Nurse workload consists of booked patients, utilising a diary system. The practice has a high EPC item workload and the nurses have a significant role with these patients. The nurses also have an important public relations role, taking responsibility for all incoming and outgoing telephone calls with a clinical content, and managing a broad recall and reminder system which includes Pap smears, immunisations, care plans and health assessments. The administration role of the nurse has been crucial in achievement of accreditation and includes responsibility for management of the treatment areas and GP consulting rooms, infection control, stock ordering, checking stock expiry dates etc. The nurses do not perform Pap smears or breast checks and only spend a limited amount of time with counselling and patient education mainly because of time constraints, limited space and the frequency of interruptions from a busy and impatient group of GPs.

The practice estimates that the nurses undertake about 50 patient care episodes per day as well as providing administration support to the GPs (chasing up pathology results, organising hospital beds etc). Given that each episode probably saves at least 4 minutes of GP time, this is worth at least 200 minutes per day. As the practice is always over subscribed and there are always more patients to see, this allows 15 to 20 more consultations per day at average $32, producing additional revenue of about $500 per day. In addition, the GPs are able to perform a high number of EPC items as well as pre-employment, insurance and other medicals, adding an estimated $300 per day to the practice income. As 55% of this additional revenue is paid to the GPs the actual benefit to the practice is approximately $450 per day or $110,000 per year. The nursing salary total for the year is about $90,000 so the actual financial benefit to the practice, while significant, is not enormous. The real benefit probably lies in the supportive clinical environment that the nurses help create, patient satisfaction, and the additional income that they help generate, which in turn all assists with GP recruitment and retention in an environment where there is a severe shortage of GPs and much competition between practices for GP services.

This practice could simply not operate without nurses as the size and complexity of the clinical operation requires constant management. The practice is able to undertake a high level of EPC utilisation and corporate medical care, which is time consuming but financially rewarding if properly managed. The practice has an impressive range of equipment, which would be likely to be under utilised if the GPs were left to operate it themselves. The availability of the nurses makes the high capital cost of equipment viable because of the frequency of use and therefore reasonable cost-recovery times. The PNs need to work as a team and be supportive of each other and the GPs. The practice has had problem in the past with PNs that have not contributed to the team or have not had a positive relationship with the GPs. It is critical that PNs are well trained and experienced, are comfortable with the private practice paradigm and are flexible in their work habits.

NURSING IN GENERAL PRACTICE CASE STUDY # 4

Size:	**Large**	*Location:*	**Metropolitan**
FTE GPs:	6.5	*FTE Practice Nurses:*	1.5
SWPEs:	6,500	*FTE Other Staff:*	7.0

The study practice is a long established large group practice occupying the ground floor of a city centre building in a large city, with 10 GPs (6.5 FTE), most of whom are partners. The practice is fully computerised, opens 8.00 to 6.00 weekdays, 8.00 to 4.00 Saturday and Sunday and 8.00 to 1.00 on Public Holidays. The practice is private billing with a standard fee of $53 for a private consultation (about 30%) with a $39 concession fee (about 35%) and some bulk billing (about 35%).

The practice employs three nurses, one of whom also has a practice management role. The nurses cover 8.00 to 5.00 weekdays and 8.00 to 1.00 Saturday. The practice nurse manager was promoted from a clinical position to a full-time staff management position but still provides back-fill when other nurses are sick, on leave or overloaded and she also runs an incontinence clinic one afternoon per week. The nurses generally see each patient for 30 minutes and then the GP reviews each patient to allow a Medicare rebate to be claimed. One of the nurses has cardiac ICU experience and has worked in an eye hospital and emergency department. She doesn't have an immunisation certificate yet so requires a detailed written order from the GP before she can give vaccines. Another of the nurses has her immunisation certificate and has had training in diabetes management and runs a diabetic clinic. In this practice the nurses book patients at the same time as the GP (health assessments, medicals, vaccinations) so that the patient is seen by the GP and the nurse during the same appointment time. Patients are also booked direct to the nurses (dressings, removal of sutures) and the GP is called to review the patient in order to claim the Medicare rebate. Triage is an important part of the PN role. The PNs also undertake ECGs, spirometry, stock and equipment control/management, infection control, procedure preparation, and are very involved in Health Assessments (in surgery ones), but not Care Plans. The practice stated that if there were extra nursing hours available they would utilize them in: - home health assessments, immunisation clinics and recruitment of more corporate clients (work cover, pre-employment medicals etc).

The practice estimated that without a nurse each GP would need 60 minutes more time to complete their work each day. If a GP sees 4 patients per hour and works 8 hours per day, the use of the nurse would therefore allow the GP to see 4 extra patients, or bill an additional $180 per day. Multiply this by the 6.5 FTE and maybe discount by 20% for hours not covered by a nurse and this calculates to $936 per day. The nurses also allow the practice to access a wider range of MBS item numbers (ECGs, spirometry etc), which has been estimated by the practice to be worth $200 per day and to access EPC / PIP items (such as Health Assessments and chronic disease PIP) which has been estimated to generate $500 per day. Thus the total income that can be attributed to the nurses is $1,630 per day; less 60% paid to the GP (which is $980) leaves a net income to the practice of $650 per day. The nurses cost the practice about $300 per day including on-costs and so the net profit to the practice is about $350 per day or $1,750/wk (on 5 day basis) = $87,500 / year.

The main benefits to the practice of employing nurses has been: the capacity to adapt to the rapid changes occurring in the General Practice environment; the ability to recruit medical staff because of the nursing support available to them; and the ability the provide a complete patient service which supports the relatively high private fees charged in this practice.

NURSING IN GENERAL PRACTICE CASE STUDY # 5

Size:	**Small**	*Location:*	**Metropolitan**
FTE GPs:	1.5	*FTE Practice Nurses:*	1.0
SWPEs:	1,155	*FTE Other Staff:*	2.5

This is a small group practice of five part-time GPs constituting 1.5 FTEs, based in a large provincial city. The practice provides a specialised service to a disadvantaged population and is staffed by a group of local GPs who receive a fixed salary for their services. The practice is owned and operated by a community consortium and is managed by a Practice Nurse Manager with seven years experience in a large group practice. The business plan of the facility is to provide a service on a cost neutral basis. The GPs that work in the practice have little control over the management or strategic development of the service. The practice operates 9.00am to 5.00pm weekdays only, with 2 GPs on duty every morning and 1 GP in the afternoon. The practice bulk-bills most patients that have access to Medicare. The practice is not accredited and therefore receives no PIP.

The practice employs a full-time equivalent Practice Nurse, composed of three part-time staff. The Practice Manager is also a registered nurse and experienced Practice Nurse. There are 1.5 FTE reception staff. The systems, procedures and protocol development are exemplary and need to be because the very part-time nature of each of the GPs, resulting in a low level of continuity between them. There are also frequent 'locum' positions filled by other local GPs 'standing in' and unfamiliar with the practice.

The practice nurses have a major administrative role in the practice although this is shared to some extent with the manager. There is a significant trauma workload in the practice and the treatment facility is well set up for minor procedures. The clinical role of the PNs includes audiometry, spirometry and ECGs, dressings, splinting (but not plastering) and counselling (although the GP workload is deliberately not allowed to be excessive so that the GPs generally have time to provide counselling themselves).

The practice income is limited by its terms of operation, to about $350,000 per year. Currently the GPs receive a salary, fixing this component of the cost base at $250,000 and as the facility is provided cost free along with most of the equipment; staff salaries dominate the remainder of the costs. Should the practice begin to become marginal or lose money, this will be because of decreased patient throughput, in which case the PM will reduce GP contact hours first, thereby saving far more than by reducing nursing hours.

This practice operates on a different principle to a private practice, in that the goal of its operation is not to make money but to provide a service to a community. The role of the Practice Nurses is not to increase the profit margin of the practice but to reduce the clinical pressure on the GPs in the practice and therefore increase the ability of the manager to recruit GPs to provide the service. Many of the GPs that work at the practice have limited recent clinical experience. This lack of up to date clinical input and 'ownership' from the GPs puts a significant responsibility on the nurses to ensure that clinical standards are set and adhered to, that competency issues with the GPs are dealt with firmly but sensitively and that clinical continuity and a high level of professional standards are maintained in the facility.

NURSING IN GENERAL PRACTICE CASE STUDY # 6

Size:	**Large**	*Location:*	**Metropolitan**
FTE GPs:	5.0	*FTE Practice Nurses:*	2.0
SWPEs:	4,800	*FTE Other Staff:*	5.0

The study practice is a well-established large group practice in a reasonably new, purpose built facility. The practice has five associates and two employee GPs. Each of the associates operates quite independently and each has specialised areas of interest covering diabetes, women's health, asthma, etc. The practice opens regular hours, 8.00 to 6.00 weekdays and 9.00 to 1.00 Saturday. The practice is fully accredited and still uses mainly paper records as two of the associates do not want electronic notes, but have computerised prescribing and administration. The practice is private billing with a standard fee of $38 and about 50% bulk-billing (some of the associates bulk-bill most patients). The practice bills about $30,000 per week to fee-for-service and receives about $100,000 per year through the PIP.

The practice employs 4 nurses. The two full-time nurses have both had more than 15 years experience and undertake advanced and specialised roles within the practice. They provide clinical support to the GPs, although several of the GPs prefer not to use them. They have separate administrative roles, with one taking responsibility for EPC, organising and conducting a number of home based health assessments, identifying suitable patients for care planning and assisting the GP with the administrative and clinical support matters as permissible under the MBS. The other nurse runs a diabetic management clinic, spending 45 minutes with each patient who is then seen by the GP. The nurse ensures that all elements of the diabetes cycle of care are completed drawing the GP's attention to elements that are still to be completed. The nurse identifies patients from the diabetes clinic that may benefit from a care plan and also draws this to the GPs attention. This clinic approach has been very successful even though not all of the GPs refer to it. A second clinic, 'healthy heart checks' has been initiated but has not yet been as popular. The other full-time nurse is a qualified asthma educator and has recently begun an asthma clinic, using the diabetic clinic model, with a view to increasing access to the Asthma SIP payments. Each of the 2 principal nurses now has an 'off-sider', working a total of nine hours per week to liberate the principal nurse to complete administrative work, while the part-timer takes over the clinical support role. One of the main roles of the support nurse is phlebotomy, with up to 50 patients per day requiring bleeding. The nurses have been asked to plaster patients in the past and have refused, as they do not feel that they have had sufficient training in this area.

One of the GPs estimated that having a nurse available saved three of the GPs (the ones that use the nurse) between 5 and 10 minutes per hour and thus save the practice 3 hours per day. The practice is heavily overbooked, so this extra time is worth (in extra consultations performed) about $2,400 per week or $120,000 per year to the practice. The practice bills $90,000 per year for health assessments, $35,000 per year for care plans and has received $40,000 in SIP payments. The GP estimated that the nurse clinics generated about $25,000 per year in additional income and the same again in reduced GP time by more efficient management of chronic disease patients.

Apart from the financial advantages that employing practice nurses has had for this practice, the nurses are also critical to the way that the practice operates and for patient satisfaction. Because the five associates run such independent practices, the nurses provide something of a unifying force, standardising some procedures and taking responsibility for management of clinical areas of the practice. They also have an important role in induction of new employee GPs.

Both principal nurses felt that practice nurses in general and they in particular, were poorly paid for the complex and responsible work required of them. They both felt that younger nurses would not be encouraged to take up the challenge of the advanced practice nurse role unless a more rewarding financial and career structure was available to them.

NURSING IN GENERAL PRACTICE CASE STUDY # 7

Size:	**Small**	*Location:*	**Metropolitan**
FTE GPs:	2.5	*FTE Practice Nurses:*	0.6
SWPEs:	2,600	*FTE Other Staff:*	3.5

The study practice is a small group of 8 part-time GPs (some very part-time) with 2 principals and a very strong preventative health focus. The practice was founded in the early 90's by the principals and occupies a converted house in the suburbs of a capital city. The practice is fully accredited, partially computerised, opens 9.00 to 5.00 / 7.00 weekdays and Saturday and Sunday mornings. The practice is private billing with a standard fee of $45 for a private consultation but with about 50% of patients being bulk billed.

The practice employed a nurse for the first time, two and a half years ago, specifically to perform home based health assessments, under the (then) new EPC items. The nurse was originally employed only 3 hours per week but has built the role up to 24 hours per week. The role is still principally EPC / SIP related, with home health assessments, administrative and clinical support for care plans (although very few of these have been done to date) and a diabetic clinic. The nurse identifies and recruits patients to this clinic from clinical notes audit (rather than direct GP referral) and uses formal guidelines to ensure patient care is in keeping with accepted guidelines. The nurse has initiated a weight reduction clinic, which has already proved very popular and has just started an asthma management clinic. The nurse has a limited clinical support role as all of the GPs prefer to do their own immunisations, women's health checks (even though the nurse is qualified to do these) and most dressings. The nurse visits some patients at home for dressings, and follow up of diabetic and elderly frail patients. The nurse books and organises her own appointments for these visits and the EPC work and sees 6 to 10 patients per day. The nurse is also responsible for infection control, use of practice equipment (although the ECG and spirometer are rarely used) and wound care. The nurse also manages the practice recall and reminder systems and has a major role in data cleansing as the practice is in the process of transferring clinical records from paper to computer based.

The principal GP estimated that without the nurse he would have to work an extra hour per day to see all of his patients and that across the practice the time saved amounted to about 12 hours per week. As the practice was fully subscribed this saving could generate an additional 40 consultations per week or around $1,400 income. As the GPs receive 60% of this as income, the practice nurse generates about $560 per week for the practice. The nurse is paid at $24.50 per hour, which with on-costs works out close to $30 per hour or about $550 per week. Thus the nurse is cost neutral before the income generated from home health assessments, diabetes SIPs, care plans etc.

Although the financial benefit of employing a practice nurse was clear, the GP asserted that this was the least important benefit as there are far more important gains in the area of quality of care, comprehensiveness of care and in professional support for the GPs which, as many of them work very limited hours, can be critical. Having said this, the main reason for not employing more nursing hours, was the cost. Should the PIP nurse incentives be extended to urban areas, this practice would jump at the opportunity to increase nursing hours and expand the nursing role.

The practice nurse appreciated the support and educational opportunities provided by the local Division but felt that the major benefit was the development and support of a very active practice nurse network.