



Australian Divisions of General Practice

# Nursing in General Practice Business Case Study

## Practice Model #1

### *The Small, Rural Practice Model*

#### Model Practice Description:

##### Practice Background:

- The model practice is one of two small practices in a rural town with a population of 5,000.
- The practice rents a modern, well-equipped facility with room for more staff.
- There is a hospital staffed by the 5 local GPs who provide a collaborative after-hours roster.
- The practice is fully accredited and receives most of the PIP potentially available.
- The practice opens 9.00am to 5.00pm with late opening to 7.00pm on Thursdays. The GPs work alternate Saturday mornings in return for one half-day off during the week

##### Medical Staff:

- Two full-time partners.
- Both are procedural GPs and are vocationally registered.

##### Other Staff:

- The practice employs two part-time reception staff (1.5 FTE) and a full-time practice manager / senior receptionist, but no nursing staff.

#### Financial Summary for Small, Rural Practice Model \*

	Income	Expenses	Net Practice Income	Profit change from baseline	Profit as % Income
Financial Statement	\$559,920	\$236,000	\$323,920	0.0%	57.9%
Special Session Model	\$580,942	\$246,500	\$334,442	3.2%	57.6%
Generalist PN Model	\$609,638	\$266,400	\$343,238	6.0%	56.3%
Advanced PN Model	\$647,772	\$294,800	\$352,972	9.0%	54.5%

\* An explanation of these figures appears on the following pages

## Practice Financial Statement:

### Financial Issues:

- The practice is private billing with a standard fee of \$40 (bulk-billing or concessionary billing rates are about 30%). Average billing rate is \$36 per patient.
- The HIC records the practice SWPE at 2,000, with 120 patients at over 75 years.
- There are about 100 diabetic patients known (about 5% of the practice population) and another 100 patients have complex chronic illnesses (and hence merit multidisciplinary care plans).
- The GPs each work 46 weeks per year – the practice operates with one GP only for 12 weeks of the year.
- The practice is very busy and has more demand than can be satisfied.
- The town is deemed RRMA 4 and so the practice receives 20% PIP rural loading and qualifies for the Practice Nurse Incentive.
- The practice utilises few EPC items (only opportunistic Health Assessments) and has enrolled for the chronic disease PIP but not yet billed any SIP items.

### Fee for service income (FFS):

- Average billing rate = \$36 / patient / consultation
- GP consultation rate = 4 consultations / hour
- Available GP consulting hours = 80 / week for 46 weeks / year
- Total FFS income per year = \$529,920 (36 x 4 x 80 x 46)

### Lump sum income (PIP):

- PIP = \$15.00 / SWPE - \$30,000 / year  
(*\$7 / SWPE for IM/IT incentive, \$4 for a/hours care, \$1.50 for other initiatives & 20% rural loading*)  
*\*These were average estimates of the PIP in 2003 when the models were developed; they may not reflect current PIP*

**Total Practice Income = \$559,920 / year** (Benchmark for this practice = \$560,000 / year)

### Staff costs: -

- Reception = 1.5 FTE = \$50,400 / year (*base salary \$28,000 x 1.5 plus 20% on-costs*)
- Practice Manager = 1.0 FTE = \$42,000 / year (*base salary \$35,000 x 1.0 plus 20% on-costs*)
- Total = \$92,400 / year (*benchmark for this practice = \$100,800 / year*)

**Practice non-staff costs = \$105,700 / year** (*entirely based on benchmark estimates*)

**Professional costs = \$37,900 / year** (*entirely based on benchmark estimates*)

**Total Practice Costs = \$236,000 / year** (*benchmark for this practice = \$246,600 / year*)

**Net Practice Income = \$323,920 / year** (*Benchmark for this practice = \$313,400 / year*)

## Financial Implications of Practice Nurse Models

### The Special Session Model

In this model, the special sessions are: - a nurse educator for one diabetes session per week and one asthma session per fortnight. The nurse see 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.

#### **Income Adjustment:**

- Insufficient nursing hours to qualify for PIP incentive

*(Only 6 hours per week on average. The PIP regulations would require a minimum of 16 hours per week for this practice to qualify for the incentive payments)*

- On average, the nurses see 12 chronic disease patients per week. This releases the GPs to consult an additional 8 patients per week

*(By reducing a potential 30 minute consultation to 20 minutes, releasing 10 minutes of GP time per patient or 120 minutes altogether. As the GPs see 4 patients per hour, this translates to 8 additional patients).*

- At an average of \$36 / patient, this equates to \$288 / week or **\$13,248** / year (46 weeks).
- Increased use of diabetes & asthma SIPs = \$105 / week and generates one care plan / week @ \$172 (85% of scheduled fee). The 45 minutes (RACGP guidelines suggest 30-60 minutes) of GP time required to perform the GP components of the care plan replaces three 15-minute consultations at \$36 each. Thus the net gain from the care plan is \$172 less \$108 (\$36 x 3) = \$64. Total = \$169 (\$105 + \$64) / week or **\$7,774** / year (46 weeks).

*(This assumes 2 diabetes SIPs / week at \$40 each = \$80 and one asthma SIP / month at \$100 = about \$25 / week. There would also be access to diabetes outcomes payments, not included here for simplicity)*

- **Total increased income = \$21,022 / year.** ( $\$13,248 + \$7,774 = \$21,022$ ).

#### **Costs Adjustment:**

- Additional staff costs of 12 hours / fortnight at \$35.00 / hour including on-costs = \$420 / fortnight = **\$10,500** / year (50 weeks).

*(\$35/hour is the average estimated casual rate paid to sessional nurses in GP and includes 25% on-costs to cover superannuation, annual, sick and long-service leave and workers compensation)*

- No additional capital or building costs as nurses utilise existing facilities.

*(Based on information from site visits conducted to practices using this model of practice nurse utilisation).*

- **Total increased costs = \$10,500 / year**

#### **Overall Adjustment:**

- **Net gain to practice = \$10,522.** ( $\$21,022$  less  $\$10,500 = \$10,522$ ).
- This increases overall net profit to \$334,442 an increase of 3.2%.

## The Generalist Practice Nurse Model

In this model, the practice employs a practice nurse for 4 sessions / week, maximising access to the PIP incentive. The nurse works 9am to 1pm Monday to Thursday in a mainly clinical support role, undertaking tasks delegated by GPs (dressings, ECGs, immunisations, spirometry). In the limited free time available 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 practice access to chronic disease initiative payments.

*These models were developed before the introduction of the Strengthening Medicare Package. Since these models were developed 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. This is not reflected in this business model*

### **Income Adjustment:**

- Additional nursing hours qualify practice for PIP incentive = \$16,000 / year.
- Nurse provides care to an average of 30 patients / week.

*(In clinical support role, nurse sees each patient for an average of 15 minutes thus providing 30 consultations in 7.5 hours. This leaves 8.5 hours for administrative and non-patient based clinical activities and for providing home based health assessments).*

- By liberating an average of 5 minutes of GP time per patient contact, this releases GPs to consult an additional 10 patients / week (assuming 15 minute consultations) at \$36 / patient = \$360 / week = \$16,560 / year (46 weeks).

*(The figure of 5 minutes of GP time liberated for each patient seen by the practice nurse, was estimated from interviews with a number of GPs that employ nurses and may well be a significant underestimate. The GP gains 5 minutes for each of the 30 patients seen by the nurse, which equates to 150 minutes of additional time, in which the GP can provide a further 10, 15-minute consultations, assuming patient demand is present (as is the case in this particular model). This model does not focus on chronic disease management therefore no factor is included for GP time liberated by nurse activity in this area. However, it would be likely that some benefit would also be apparent, though less than for the first model).*

- Increased EPC item number access with Home Health Assessments x 2 / week @ \$ 189 (85% of scheduled fee) = \$378 Increased access to SIP incentives also adds \$75 / week and one care plan / week adds \$172 (85% of scheduled fee). This combines to provide an additional \$625 (\$378+ \$75 + \$172), less \$252 for GP time (see notes below) = \$373 per week or \$17,158 / year (46 weeks).

*(This practice has 120 patients that qualify for health assessments. This assumes 100 of these patients consent to home based, nurse conducted assessments. GP time spent completing the health assessments after the nurse has undertaken some of the necessary components 30 minutes each (RACGP guidelines suggest 30 minutes) and the one care plan per week 45 minutes (RACGP guidelines suggest 30-60 minutes. This is equivalent to seven 15 minute consultations (HHAX2X30 minutes each plus Care Plan 1x45 minutes =105 minutes), the value of which (\$36 x 7 = \$252) is deducted from the gain received from the EPC item payments. The SIP payments are less than for the first model as the nurse is not conducting specific diabetes and asthma clinics).*

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

- **Total increased income = \$49,718 / year.** (\$16,000 + \$16,560 + \$17,158 = \$49,718).

### **Costs Adjustment:**

- Additional staff costs of 16 hours per week at \$28 / hour including on-costs = \$448 / week = \$22,400 per year, (50 weeks see previous model for explanation of on-costs).

*(This item uses \$28 / hr including on-costs, as the appropriate rate for a PN employed on permanent part-time basis & is thus less than the \$35 per hour estimate for the more specialised nurse undertaking isolated 4-hour sessions in the first model. These figures are based on industrial award rates and the actual rates being paid in a number of practices consulted during this study)*

### The Generalist Practice Nurse Model cont.

- Capital costs of one additional computer with appropriate software, one additional telephone and some low level building alterations = **\$3,000** / year.

*(Based on \$4,000 for computer & networking, \$2,000 for software & telephone costs and an allowance of \$3,000 for building and fit out costs, based on information from site visits conducted to practices using this model of practice nurse utilisation and information from the validation workshop and NSC. This total of \$9,000 is amortised over 3 years).*

- Additional stock and other supplies - \$100 / week = **\$5,000** / year.

*(Based on information from site visits conducted to practices using this model of practice nurse utilisation).*

- **Total increased costs = \$30,400 / year.** ( $\$22,400 + \$3,000 + \$5,000 = \$30,400$ ).

#### **Overall Adjustment:**

- **Net gain to practice = \$19,318.** ( $\$49,718$  less  $\$30,400 = \$19,318$ ).
- This increases net profit to \$343,238 an increase of 6.0%.

## The Advanced Practice Nurse Model

In this model, the nurse is employed for 8 sessions per week, operates fortnightly 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 nurse role would probably be split between 2 or more part-time nurses to provide the range of skills / qualifications required and to ensure backfill cover for annual, sick & study leave. The nurse manages the EPC program conducting 2 home health assessments per week, and identifying patients who would benefit from a care plan. The nurse has certificates in woman's health and is a qualified Diabetes Nurse Educator and Asthma Nurse Educator. The nurse requires 2 days release per month 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 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. This is not reflected in this business model.*

### **Income Adjustment:**

- Additional nursing hours (32 / week) qualify practice for PIP incentive = \$16,000 / year.
- The nurse provides 12 hours direct clinical support, 4 hours administration (including accreditation), 8 hours chronic disease management / nurse clinics and 8 hours of EPC / week.
- The clinical support role liberates 5 minutes of GP time per patient seen. *(See previous models)*
- Patients seen in 12 hours allocated to clinical support time = 48 / week. *(See previous models)*
- By liberating an average of 5 minutes of GP time per patient contact, this releases GPs to consult an additional 16 patients / week at \$36 / patient = \$576 / week = \$26,496 / year (46 weeks).

*(Figure of 5 minutes GP time liberated per patient seen by practice nurse is explained in previous models. The GP gains 5 minutes for each of the 48 patients seen by the nurse, which equates to 240 minutes of additional time, in which the GP can provide an estimated 16, 15-minute consultations, as high demand is present in this particular model).*

- The chronic disease management role reduces GP time with these patients from 30 mins to 20 mins and therefore liberates 10 mins of GP time per complex patient seen by nurse. The nurse sees 2 patients per hour during the 8 hours per week allocated to this role, totalling 16 patients seen by nurse. This liberates 160 mins of GP time during which GP can potentially see further 10 patients, at an average of \$36 / patient, which equates to \$360 / week or \$16,560 / year (46 weeks).
- Increased access to diabetes, asthma and cervical screening SIP incentives adds \$200 / week or \$9,200 / year (46 weeks).

*(Based on \$40 / diabetes SIP @ 2 / week, \$100 / asthma SIP @ 1 / week & \$35 / cervical screening SIP @ 1 / fortnight. Diabetes and cervical screening outcomes payments are not included for simplicity)*

- Increased EPC access with Home Health Assessments x 2 / week (@ \$189, 85% of scheduled fee) and care plans x 3 / week (@ \$172, 85% of scheduled fee), totalling \$894 (less GP time factor of \$468 as below) = \$426 / week or \$19,596 / year (46 weeks).

*(As in previous models, the GP loses 30 minutes (RACGP guidelines suggest 30 minutes) of consulting time per health assessment and 45 minutes per care plan. RACGP guidelines suggest 30-60 minutes.. Thus in this model, GP time lost is 195 minutes (2 x 30 plus 3 x 45) which equates to 13 consultations at \$36 or \$468, which is subtracted from the income from the EPC items)*

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

- **Total increased income = \$87,852 / year.** (\$16,000 + \$26,496 + \$16,560 + \$9,200 + \$19,596 = \$87,852).

## The Advanced Practice Nurse Model cont.

### **Costs Adjustment:**

- Additional staff costs of 32 hours / week at \$28.00 / hour including on-costs = \$896 / week = \$44,800 per year (50 weeks). *(Pay rates used and on-costs are explained in the previous models).*
- Capital costs of one additional computer with appropriate software, one additional telephone and a moderate level of building alterations = \$4,000 / year

*(Based on \$4,000 for computer & networking, \$2,000 for software & telephone costs and an allowance of \$6,000 for building and fit out costs, based on information from site visits conducted to practices using this model of practice nurse utilisation and information from the validation workshop and NSC. This total of \$12,000 is amortised over 3 years).*

- Additional stock and equipment - \$200 / week = \$10,000 / year. *(See previous models)*
- **Total increased costs = \$58,800 / year.** *(\$44,800 + \$4,000 + \$10,000 = \$58,800).*

### **Overall Adjustment:**

**Net gain to practice = \$29,052.** *(\$87,852 less \$58,800 = \$29,052).*

This increase net profit to \$352,972 an increase of 9.0%.