



**Australian Government**  
**Department of Health and Ageing**

# Practice Nurse Incentive Program Guidelines

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# Introduction

The Practice Nurse Incentive Program (PNIP) commences on 1 January 2012.

The PNIP provides incentive payments to practices to support an expanded and enhanced role for nurses working in general practice.

General practices across Australia, including those in urban areas as well as Aboriginal Medical Services and Aboriginal Community Controlled Health Services may be eligible for an incentive to offset the costs of employing a practice nurse. Part of the eligibility requirement is that your practice is accredited under the current Royal Australian College of General Practitioners *Standards for general practices*.

The new arrangements will also include:

- support for all accredited practices to employ an Aboriginal Health Worker instead of or in addition to a practice nurse (Registered Nurse or Enrolled Nurse).
- support for practices in urban areas where there are workforce shortages and Aboriginal Medical Services and Aboriginal Community Controlled Health Services to employ allied health professionals such as physiotherapists, dietitians and occupational therapists, instead of, or in addition to a practice nurse and/or Aboriginal Health Worker.
- a rural loading of up to 50% based on Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA).
- a one-off \$5,000 incentive to support eligible non-accredited practices to become accredited.
- grandparenting arrangements for the first three years of the program to ensure that practices are not financially disadvantaged by the restructure of the Practice Incentives Program Practice Nurse Incentive and the removal of six of the Medicare Benefits Schedule (MBS) practice nurse items.
- a loading for Aboriginal Medical Services and Aboriginal Community Controlled Health Services; and
- a loading for practices that provide General Practitioners (GP) services to Department of Veterans' Affairs Gold Card holders.

The PNIP simplifies previous financing arrangements by consolidating funding under the Practice Incentives Program Practice Nurse Incentive and MBS practice nurse items and redirecting them into a single payment to eligible general practices effective from 1 January 2012.

From 31 December 2011, the following MBS practice nurse items covering immunisation, cervical smears, and treatment of a person's wound will no longer be available:

- 10993
- 10994
- 10995
- 10996
- 10998
- 10999

The PNIP is administered by Medicare Australia on behalf of the Australian Government Department of Health and Ageing and the Australian Government Department of Veterans' Affairs.

These guidelines are primarily designed to inform eligible general practices applying for payments under the PNIP and to explain the new arrangements that will be in place.

**Attachment A** contains a number of different payment calculation scenarios.

Payments under the PNIP will be paid to eligible general practices that apply for the PNIP. Practices not eligible for incentive payments under the PNIP, may still be eligible for the grandparenting payment under the program if they are financially disadvantaged by the removal of six of the MBS practice nurse items.

The level of incentive payment a practice may be entitled to will be dependent upon the practice's SWPE value and the number of hours worked by practice nurses at the practice. More information on the calculation of a practice's SWPE value and practice nurse hours can be found in the section: **Payments**.

## Is my practice eligible?

To be eligible to participate in the PNIP, a practice must:

- meet the RACGP definition of a 'general practice' as defined in the current RACGP *Standards for general practices*;
- maintain full accreditation or be registered for accreditation against the RACGP *Standards for general practices*;
- achieve full accreditation within 12 months of joining the PNIP and maintain full accreditation thereafter;
- maintain current public liability insurance;
- ensure that all practice GPs maintain current professional indemnity cover;
- ensure that all practice nurses, Aboriginal Health Workers and allied health professionals (where applicable) are covered by appropriate professional indemnity insurance arrangements as required by the Australia Health Practitioner Regulation Agency or by the professional's registration board;
- employ or otherwise retain the services of eligible practice nurses and/or Aboriginal Health Workers; and
- employ or otherwise retain the services of a GP. This may include less than one full time GP.

All practices eligible under the above criteria can apply for incentives through the PNIP to support the employment and/or retention of:

- Registered Nurses; and/or
- Enrolled Nurses; and/or
- Aboriginal Health Workers.

In addition, practices in urban areas of workforce shortage and Aboriginal Medical Services and/ or Aboriginal Community Controlled Health Services can apply for support through the PNIP to employ or otherwise retain the services of an allied health professional instead of, or in addition to, practice nurses or Aboriginal Health Workers. Allied health professionals eligible to participate in the PNIP are listed below:

- Audiologists
- Chiropractors
- Diabetes Educators
- Dietitians/Nutritionists
- Exercise Physiologists
- Occupational Therapists
- Orthoptists
- Orthotists/Prosthetists
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Social workers
- Speech pathologists

For the purposes of the PNIP, areas of workforce shortage are determined by the Department of Health and Ageing.

## Minimum Qualifications of practice nurses and health professionals

To be eligible for the PNIP, practice nurses, Aboriginal Health Workers and/or allied health professionals where applicable, working in the practice must meet the minimum qualifications described below.

Registered Nurses and Enrolled Nurses must have current registration with the Nursing and Midwifery Board of Australia as part of the National Registration and Accreditation Scheme and meet minimum specified qualifications and training appropriate to the functions undertaken.

Professional nursing standards require that an Enrolled Nurse must be supervised by a Registered Nurse. Supervision may be direct or indirect, but appropriate supervisory arrangements must be in place.

For further details see **Attachment B – Roles for nurses in general practice settings**.

Aboriginal Health Workers must hold a Certificate Level III or above in Aboriginal and Torres Strait Islander Health from a recognised institute. To obtain a comprehensive list of approved courses and training for Aboriginal Health Workers, email [pnip@medicareaustralia.gov.au](mailto:pnip@medicareaustralia.gov.au) or call **1800 222 032** (call charges may apply) between 8.30 am and 5.00 pm, Monday to Friday, Australia Central Standard Time (ACST).

Allied health professionals must hold recognised educational qualifications specific to the position for which they are employed and relevant registration, accreditation or membership with the profession where required. Allied health professionals must not require supervision to undertake clinical tasks for which they are employed or engaged.

## How does my practice apply for the PNIP?

Practices may apply to join the PNIP at any time from 1 October 2011. Application forms will be available from this date on the Medicare Australia website at [www.medicareaustralia.gov.au/pnip](http://www.medicareaustralia.gov.au/pnip)

Medicare Australia will advise practices in writing of receipt of their application form. All applications received will be assessed for eligibility from 1 January 2012.

To be eligible for a payment in February 2012 the application must be received by Medicare Australia on or before Friday, 31 January 2012.

From 1 January 2012, practices may apply for the PNIP via the PNIP Online system. Only the practice's owner(s) or the authorised contact person(s) can apply on behalf of the practice to join the PNIP. Practices must include the name and contact details of the authorised contact person(s) for the practice. The contact person(s) must be authorised by the current owner(s) of the practice to advise Medicare Australia of any changes and will be the person(s) to whom all correspondence or enquiries are addressed. Medicare Australia can only communicate with the current owner(s) or authorised contact persons(s).

To safeguard practice and GP information, the PNIP Online system will be available as part of the secure Health Professional Online Services (HPOS) system. HPOS offers improved access to Medicare Australia's online services for health professionals through a single entry point.

Once the online system becomes available, practice owners and authorised contact persons must have a Public Key Infrastructure (PKI) individual certificate to access the system. To register for a PKI individual certificate complete an application form available from [www.medicareaustralia.gov.au](http://www.medicareaustralia.gov.au) > **For Health Professionals > Doing business with Medicare Australia > Online Business > Register > Applying for certificates** or contact the eBusiness Service Centre on **1800 700 199**.

If practice owners, or authorised contact persons already have a PKI certificate and require assistance with installation, access or other technical difficulties they can contact the eBusiness Service Centre on **1800 700 199**.

Practice and GP information is secure by limiting system access only to those persons who have a PKI individual certificate that has been linked to the practice. To do this, the PKI individual certificate's unique (10 digit) Registration Authority (RA) number must be recorded against the practice's PNIP Online system.

A practice may request a hardcopy of the application form from Medicare Australia if access to the internet is not available. Practices will be able to apply for all payments under the PNIP via the one form.

Medicare Australia will assess applications and advise applicants in writing of their eligibility.

## Consent to Share data – Practices Participating in the Practice Incentives Program

It is important that practices that are participating in the Practice Incentives Program provide consent to Medicare Australia to access the practice's Practice Incentives Program data including their Standardised Whole Patient Equivalent (SWPE). Providing consent will streamline the application process and ensure a practice's PNIP details are the same as their Practice Incentives Program details.

If a practice does not provide consent, this will result in a duplication of practice data that is already stored in the Practice Incentive Program Medicare Australia system. It will also prevent the use of an existing practice's SWPE value, resulting in a SWPE value of 1,000 being applied for 18 months or until the practice has built up a unique PNIP SWPE value greater than 1,000.

All GPs working at the practice must also provide consent to use their MBS billing data so that Medicare Australia can use the practice's existing SWPE value. Each practice GP is required to complete the General Practitioner Details and Declaration section of the application form. GPs that later join a practice already participating in the PNIP will need to complete and submit the General Practitioner Details and Declaration form.

If GPs working at the practice do not provide consent, their service data will be excluded from the calculation of the practice's payments.

GPs may consent at a later date to have their service data included by advising Medicare Australia of this decision in writing. The GP service data will then be included in the calculation of the practice's payments from the next payment date.

In addition, where the practice is eligible for a top-up payment Medicare Australia can only include the MBS practice nurse billing data for the consenting GPs.

## What evidence does my practice need to provide at the time of application?

Practices will be required to provide evidence of the following at the time of application for PNIP:

- evidence of current accreditation, or registration for accreditation via a certificate of accreditation or registration for accreditation or other documentation issued from the accreditation body\*.
- evidence that the practice employs or otherwise retains the services of a practice nurse, Aboriginal Health Worker or allied health professional (where applicable). This will be validated by a letter on letterhead at the time of application and the quarterly confirmation statements.
- evidence that the practice employs or otherwise retains the services of a GP in the situation where the practice is new. This will be validated by a letter on letterhead at the time of application and through the quarterly confirmation statements.

\*Evidence of accreditation will not be required for those general practices that are only applying for grandparenting payments.

Practices will be able to electronically submit the requested evidence as an attachment to their application form. Practices may also post or fax relevant documentation. If posting, please ensure practice details are clearly visible on the application form and evidence and submit to:

Mail: **Practice Nurse Incentive Program**  
**GPO BOX 2572**  
**ADELAIDE SA 5001**

Fax: **1300 587 696**

Email: **pnip@medicareaustralia.gov.au**

Medicare Australia will only assess fully completed applications and advise applicants in writing of their eligibility.

## Other evidence requirements

In addition to the abovementioned documentation, to be eligible for this program, practices must be able to substantiate the following if requested by Medicare Australia:

- appropriate insurance coverage, including:
  - » public liability insurance coverage;
  - » professional indemnity cover for GPs;
  - » all practice nurses, aboriginal Health Workers and allied health professionals must be covered by appropriate professional indemnity insurance arrangements required by the Australian Health Practitioner Regulation Agency or by the professional's registration body; and
  - » evidence of the hours worked by Practice Nurses, Aboriginal Health Workers and allied health professionals, for example timesheets.

## Practices with multiple locations

Practices with multiple locations may apply to join the PNIP as a single practice provided the eligibility requirements set out below are met. Practices will need to nominate the main practice location when completing the application form. The main practice location should be the practice location that provides the highest number of MBS services per annum. For the purposes of the PNIP, additional practice locations are known as practice branches.

## Eligibility requirements

To be considered eligible as a practice branch for the purposes of the PNIP:

- MBS services must be provided from the practice branch;
- one or more GPs must provide MBS services at both the main practice and the practice branch;
- the practice branch must maintain current public liability insurance;
- all GPs at the practice branch must maintain current professional indemnity cover; and
- all practice nurses at the practice branch must be covered by appropriate professional indemnity insurance arrangements.

## Accreditation requirements

Practice branches providing less than 3,000 services per annum do not need to be accredited in their own right to be eligible to participate in the PNIP. The MBS services of these practice branches will be automatically included in the calculation of the practice's PNIP payments, regardless of accreditation status.

Practice branches providing 3,000 or more services per annum need to maintain full accreditation or be registered for accreditation in their own right, for services to be included in the calculation of the practice's PNIP payments. If the practice branch is registered for accreditation, full accreditation must be achieved within 12 months of joining the PNIP and maintained thereafter.

See also **Withheld Payments** section.

## Payments

### Incentive Payments

Payments under the PNIP are calculated quarterly and will be stratified with one incentive equating to:

- \$25,000 per annum, per 1,000 SWPE where a Registered Nurse works at least 12 hours 40 minutes per week; and
- \$12,500 per annum, per 1,000 SWPE where an Enrolled Nurse or Aboriginal Health Worker works at least 12 hours and 40 minutes per week.

Practices in urban areas of workforce shortage, Aboriginal Medical Services and Aboriginal Community Controlled Health Services are also eligible for funding of \$25,000 per annum per 1,000 SWPE to employ or otherwise retain the services of an eligible allied health professional who works 12 hours 40 minutes per week. Medicare Australia will advise a practice if they are in an urban area of workforce shortage.

A practice may be eligible for a maximum of five incentive payments.

The calculation of the payment made to a practice can include a combination of incentives for Registered Nurses, Enrolled Nurses and Aboriginal Health Workers (and allied health professional where applicable). Where a practice uses the services of Registered Nurses, Enrolled Nurses, Aboriginal Health Workers and/or allied health professionals, where applicable, the higher incentive of \$25,000 will be applied first.

### EXAMPLE

If a practice has a SWPE value of 1,000 and the practices nurses work 38 hours per week (1 Registered Nurse works 28 hours per week and 1 Enrolled Nurse works 10 hours per week), the Registered Nurse incentive will be applied first. See also: Scenarios at Attachment A.

## Rural Loading

A rural loading will be applied to each incentive (or part thereof) for which a practice is eligible. Rural loadings will be applied to the PNIP incentive payments only and will not apply to grandparenting, top up or accreditation assistance payments. The rural loading will be based on the ASGC-RA classification system in Table 1.

Table 1

Remoteness Classification	Rural Loading per PNIP incentive only
RA1 Major City	0%
RA2 Inner Regional	20%
RA3 Outer Regional	30%
RA4 Remote	40%
RA5 Very Remote	50%

# Calculation of payments

## Calculation of a full time practice nurse

For the purposes of the PNIP, a full time practice nurse is equivalent to 38 hours per week.

## Calculation of a full time GP

For the purposes of the PNIP, the calculation of a full time GP will be based on a practice's Standardised Whole Patient Equivalent (SWPE) value. One full time GP is equivalent to a SWPE value of 1,000. Medicare Australia will determine a practice's SWPE value based on MBS data of the GPs working in the practice who consent to the use of their data.

Table 2

SWPE	Minimum number of practice nurse hours per week required for full incentive payment	Incentive Amount for a Registered Nurse (or allied health professional, where applicable)	Incentive Amount for an Enrolled Nurse or Aboriginal Health Worker
1,000	12 hours 40 minutes	\$25,000	\$12,500
2,000	25 hours 20 minutes	\$50,000	\$25,000
3,000	38 hours	\$75,000	\$37,500
4,000	50 hours 40 minutes	\$100,000	\$50,000
5,000	63 hours 20 minutes	\$125,000	\$62,500

Where a practice has a SWPE value of less 1,000 or does not have the minimum number of practice nurse hours per week, a proportionate payment will apply.

To account for differing working hours of GPs and practice nurses/Aboriginal Health Workers (and allied health professionals where applicable), payments will be paid pro rata.

### EXAMPLE

A practice with a SWPE value of 1,200 will receive 1.2 incentives, provided they employ or otherwise retain the services of a practice nurse, Aboriginal Health Worker or allied health professional (where applicable) that works at least 15 hours 12 minutes (1.2 x 12 hours 40 minutes) per week. If the practice has an RN working for 15 hours 12 minutes, this would result in a payment of \$30,000 per annum or \$7,500 per quarter.

If this is not the case, the practice will be paid an amount pro rata (i.e. if the practice nurse works only 10 hours per week, the incentive amount will be based on those hours worked).

## Calculating the SWPE Value

The SWPE value of a practice is the sum of the fractions of care provided to practice patients, weighted for the age and gender of each patient. The average full time GP has 1,000 SWPEs annually. The SWPE value of a practice is calculated in three steps:

### 1. Calculation of the Whole Patient Equivalent (WPE) of each patient

The fraction of care provided by the practice to each patient is calculated. For example, in a 12 month period, a patient has \$100 in MBS benefits at Practice A and \$400 at Practice B, a total of \$500.

- Practice A would be assigned with  $\$100 \div \$500$  or 0.2 of the patient's care
- Practice B would be assigned with  $\$400 \div \$500$  or 0.8 of the patient's care.

The total care for each patient equals one (1.0) and is known as the whole patient equivalent (WPE). The WPE is based on GP and other non-referred consultation items in the MBS and uses the value, rather than the number, of consultations per patient.

### 2. Weighting of the WPE

The WPE is weighted for the age and gender of each patient to become the SWPE. The weighting factor recognises that people generally require different amounts of care at different stages in their life, and that the amount of care differs for males and females. The weighting factors are routinely updated and are available on the Medicare Australia website.

### 3. Sum the SWPE

The individual SWPE values are added together to determine the SWPE value of the practice.

## Practices without an historical SWPE

As newly established practices and practices previously not participating in the Practice Incentives Program will not have a historical SWPE value, they will be given a start up allocation equal to a SWPE value of 1,000. In addition, practices that do not consent to the use of their Practice Incentives Program data will also receive a start-up SWPE value of 1,000. This means that these practices will be eligible to apply for a payment under the PNIP, if they meet all other eligibility criteria.

It takes approximately six payment quarters from the time of joining the PNIP to establish a full SWPE value. From this point forward, the SWPE value will be used, even if it is lower than 1,000. If during the 18 month period the practice's SWPE value is more than 1,000, the actual SWPE value will be used to calculate payments.

## Aboriginal Medical Services and Aboriginal Community Controlled Health Services

The SWPE values for Aboriginal Medical Services and Aboriginal Community Controlled Health Services will be increased by 50%.

## What if my practice is financially disadvantaged by the introduction of the PNIP?

If a practice is assessed as being financially disadvantaged by the introduction of the PNIP, payments will be made to the practice for the first three years of the program (1 January 2012 to 31 December 2014) to address this disadvantage.

## What if my practice is eligible for PNIP incentive payments but is assessed as financially disadvantaged?

Top-up payments will be available for the first three years of the program to ensure that accredited practices are not financially disadvantaged by the cessation of the Practice Incentives Program Practice Nurse Incentive and/or the removed six MBS practice nurse items. Top-up payments will be available until 31 December 2014.

A top-up payment is paid **only** to accredited practices or practices that are registered for accreditation that join the PNIP and are financially disadvantaged resulting from a loss of income previously received under the Practice Incentives Program Practice Nurse Incentive and/or the removed MBS practice nurse items.

An assessment of the applying practice's historical practice nurse income (including the removed six MBS practice nurse items and any incentive amount received under the Practice Incentives Program Practice Nurse Incentive) will be undertaken by Medicare Australia, in order to determine if the practice is disadvantaged and eligible for top-up. The assessment will cover the practice nurse income over the 12 month historical period. For the purpose of the PNIP, the historical period is the 12 month period from 1 August 2010 to 31 July 2011. Medicare Australia will assess all applications for top-up payments.

Practices in this situation will be provided with a top-up payment, in addition to the PNIP incentive payments it will receive. The top-up amount will be equivalent to the difference between the amount received under the Practice Incentives Program Practice Nurse Incentive and/or the removed six MBS practice nurse items and the amount paid through the PNIP incentive payments. To continue to receive the maximum top-up payment, the practice must maintain its GP and practice nurse workforce and its practice nurses must continue to work at least the same number of hours as are recorded in the relevant quarter of the historical period. For example during the historical period a practice has a Registered Nurse working 19 hours and an Enrolled Nurse working 19 hours. This must be maintained in order for the practice to receive the maximum top-up payment.

Practices will need to provide the required information as identified on the application form for Medicare Australia to determine if the practice is financially disadvantaged. In order for practices to receive the maximum amount of top-up payment it is important for practices and practice GPs to provide consent for the use of their Practice Incentive Program data and historical MBS data to calculate the payment. This includes the GPs who worked at the practice in the historical period (1 August 2010 – 1 July 2011).

Practices will have until 30 June 2012 to apply for a top-up payment. After this date, no applications for top-up will be accepted. Practices that apply for top-up payments after 1 January 2012 but before 30 June 2012 will have their top-up payments backdated to 1 January 2012 or the earliest calculated eligibility date.

See **Attachment A** for an example of how top-up payments are calculated.

Practices will need to ensure GPs who were employed at the practice during the 12 month historical period sign an Individual General Practitioner Details and Declaration consenting to the use of their historical MBS data to calculate the practice's top-up payment. Where applicable, practices will need to consent to the use of their Practice Incentives Program Practice Nurse Incentive data to calculate the top-up payment.

If a GP does not consent to providing details of their provider numbers, or omits to sign the relevant part of the application form, their service data will be excluded from the calculation of the practice's top-up payment. GPs must provide their consent for the use of their details for top up at the time the application is lodged with Medicare Australia.

## What if my practice is not eligible for the PNIP incentive payments but is financially disadvantaged?

Grandparenting payments will be available for the first three years of the program to ensure that non accredited practices are not financially disadvantaged by the removed six MBS practice nurse items. Grandparenting payments will be available until 31 December 2014.

Grandparenting is **only** available to non-accredited practices that are not eligible for the incentive payments under the PNIP and are financially disadvantaged by the removal of the six MBS practice nurse items.

See **Attachment A** for an example of how grandparenting payments are calculated.

Grandparenting enables an ineligible practice to be paid an amount quarterly up to the income it would have earned from the removed six MBS practice nurse items. Grandparenting payments will be based on MBS billing history from the relevant quarter in the historical period. To continue to receive the maximum grandparenting payment the practice must maintain its GP and practice nurse workforce and its practice nurses must continue to work at least the same number of hours as are recorded in the relevant quarter of the historical period. For example during the historical period a practice has a Registered Nurse working 19 hours and an Enrolled Nurse working 19 hours. This must be maintained in order for the practice to receive the maximum grandparenting payment. For the purpose of the PNIP, the historical period is the 12 month period from 1 August 2010 to 31 July 2011.

Practices will need to provide the required information for Medicare Australia to determine if the practice is financially disadvantaged. In order for practices to receive the maximum amount of grandparenting it is important for practice GPs to provide consent for the use of their historical practice nurse MBS data to calculate the payment. This includes the GPs who worked at the practice in the historical period (1 August 2010 – 1 July 2011).

Practices will have until 30 June 2012 to apply for grandparenting arrangements. After this date, no applications will be accepted. Practices that apply for grandparenting payments after 1 January 2012 but before 30 June 2012 will have their payments backdated to 1 January 2012.

An assessment of the applying practice's historical practice nurse income from the removed six MBS practice nurse items will be undertaken by Medicare Australia, in order to determine if the practice is financially disadvantaged and eligible for grandparenting. The assessment will cover the practice nurse income over the 12 month historical period.

Practices will need to ensure GPs who were employed at the practice during the 12 month historical period sign an Individual General Practitioner Details and Declaration consenting to the use of their historical practice nurse MBS data to calculate the practice's grandparenting payment.

GPs must provide their consent for the use of their details for grandparenting at the time the application is been lodged with Medicare Australia. If a GP does not consent to providing details of their provider numbers, or omits to sign the relevant part of the application form, their historical practice nurse MBS data will be excluded from the calculation of the practice's grandparenting payment.

A practice in receipt of the grandparenting payment that registers for accreditation may be eligible to join the PNIP. Medicare Australia will assess the practice to determine if it is still financially disadvantaged and eligible for a top-up payment instead of a grandparenting payment.

## Department of Veterans' Affairs loading

Practices that are eligible for the PNIP and provide GP services to Department of Veterans' Affairs entitled persons will be eligible to an annual, per veteran payment.

These practices will be identified by Medicare Australia.

The Department of Veterans' Affairs loading will be calculated by determining the number of Gold Card holders who receive an 'in rooms' consultation in an eligible practice during each year. An amount will be paid for each Department of Veterans' Affairs Gold Card holder, regardless of the practice location, nursing qualifications or the number of nurses per practice. There are no limitations on the number of Department of Veterans' Affairs loadings paid per practice.

Where a Gold Card holder chooses to use more than one practice each year, the Department of Veterans' Affairs loading will be apportioned across the practices based on the percentage of total consultation fees paid.

### EXAMPLE

Mr Smith is a Gold Card Holder and visits three GP practices in a 12 month period, receiving services as follows:

Table 3

Practice	Service Items	% Total Annual Cost	% Total DVA Component
A	2 x item 23	29%	29%
B	3 x item 23; 1 x item 36	57%	57%
C	1 x item 23	14%	14%

## Accreditation assistance

To be eligible for the one-off \$5,000 accreditation assistance incentive payment, a practice must be registered for accreditation against the *RACGP Standards for general practices*. Practice branches are not eligible for the \$5,000 payment.

The practice must also join the PNIP, provide Medicare Australia with proof of registration for accreditation on application and become accredited within 12 months of joining the PNIP.

If a practice withdraws or has its payments ceased from the PNIP and subsequently reapplies for payment under the PNIP, the practice will not be entitled to another accreditation assistance payment.

## When payments are made

Payments will be calculated and paid retrospectively on a quarterly basis.

To qualify for payments, practices must have fully lodged their application for the PNIP by the 'point in time date'. The 'point in time' date corresponds to the last day of the month prior to the next PNIP quarterly payment. The quarterly payment months, 'point in time' dates and reference periods are provided in Table 4.

Table 4

Quarterly payment month	'Point in time' assessment of eligibility	Reference period
February	31 January	1 November to 31 January
May	30 April	1 February to 30 April
August	31 July	1 May to 31 July
November	31 October	1 August to 31 October

The quarterly payment is made in acknowledgement of a practice having already met the eligibility requirements for a particular payment in the reference period. For example, the May quarterly payment for the PNIP is made for **having met** the eligibility requirements in February, March and April or part thereof.

The Department of Veterans' Affairs loading will be made by Medicare Australia on the same date as payment for the final quarterly instalment of the PNIP payments in each year. The payment advice will identify each eligible veteran for whom a payment is made.

## How payments are made

PNIP payments are made by Electronic Funds Transfer to the account nominated by the practice in the application form. PNIP payments do not attract Goods and Services Tax.

## February 2012 payment

Medicare Australia will make the first payment in February 2012 to practices that have applied and been assessed for a PNIP payment (including grandparenting, top up and accreditation assistance).

As PNIP commences on 1 January 2012, the February 2012 payment will cover only the last month of the quarter (i.e. January 2012).

For practices previously participating in the Practice Incentives Program, the first payment is based on the practice's SWPE value in the last quarter before the cessation of the Practice Incentives Program Practice Nurse Incentive (i.e. November 2011) and the practice nurse hours reported on application. The incentive payment will be calculated and then the total amount will be divided by three, resulting in an amount for one month.

For new practices, the first payment is based on a SWPE value of 1,000 and the practice nurse hours reported on application. The incentive payment will be calculated and then the total amount will be divided by three, resulting in an amount for one month.

## Withheld payments

Payments to practices may be withheld by Medicare Australia for a number of reasons including, but not limited to:

- the practice no longer employs a GP;
- the practice no longer employs a Registered Nurse, Enrolled Nurse, Aboriginal Health Worker or allied health professional (where applicable);
- an Enrolled Nurse is not supervised by a Registered Nurse;
- a change of practice ownership;
- non-compliance;
- expiry of accreditation status;
- significant variance of practice data;
- the practice or practitioners do not have the required current insurances; and/or
- incomplete or inaccurate practice details.

Practices are required to confirm practice details before calculation of the quarterly payment (See **Maintaining and Changing Practice Information**). If practices do not confirm details in the quarterly confirmation statements provided by Medicare Australia, PNIP payments will be withheld. Medicare Australia will notify practices of the reason payments have been withheld and what information needs to be provided in order for payments to be released (See **Maintaining and Changing Practice Information**).

Once the required information is provided and the practice is assessed as eligible for payments, Medicare Australia will release the payment/s.

Where a practice is not meeting the PNIP eligibility requirements (for example lapsed accreditation, insurance requirements or not confirming its details through the quarterly confirmation statement process) and payments are withheld by Medicare Australia for three consecutive 'points-in-time', the practice's entitlement will be ceased under the PNIP the day after the third point-in-time. In addition, practices that have their quarterly payment calculated to be \$0 at three consecutive 'points-in-time' will have their entitlement ceased under the PNIP.

If a practice's entitlement has been ceased under the PNIP, the practice will not be eligible to receive any withheld payments relating to the incentive and must reapply to participate in the PNIP in the future. Further to this, if a practice re-applies for the PNIP, payments will recommence from the date of full lodgement of the new application, even if the applicant resumed its eligible status prior to lodging a new application. No back payments will be made to these practices.

If the reason for payments being withheld is subsequently resolved following a practice's withdrawal from the PNIP or cessation of entitlement, the practice will need to complete a new application form to re-join the PNIP. Practices rejoining the PNIP will need to be fully accredited to receive PNIP payments. Practices will be unable to reapply for grandparenting or top-up arrangements after 30 June 2012.

If a practice receives an extension on their registration for accreditation, payments will be withheld until evidence of accreditation is provided. Practices are given 12 months from application to join the PNIP to obtain accreditation, and are not eligible for any further payments beyond this period. Once accreditation is achieved, payments will commence from the date of accreditation. The practice will be ceased from the PNIP if the practice does not have full accreditation by the third point-in-time after the 12 month registration period expires.

If a practice has applied for re-accreditation, payments will be withheld until confirmation of re-accreditation is received. The full payment/s will only be released if the practice was accredited for the full period that payments were withheld. The practice will be ceased from the PNIP if the practice has not provided evidence of re-accreditation by the third consecutive point-in-time after the accreditation expired as per Table 5.

In all cases where a practice is ceased from the PNIP or has their entitlement ceased, withheld payments will be forfeited.

Table 5

1st point-in-time	2nd point-in-time	3rd point-in-time	Practice's entitlement to PNIP ceases
31 January	30 April	31 July	1 August
30 April	31 July	31 October	1 November
31 July	31 October	31 January	1 February
31 October	31 January	30 April	1 May

## Recovery of payments

In circumstances where PNIP payments have been made as a result of an administrative error or inappropriate claiming, Medicare Australia may seek to recover these payments.

## Payment advices

Practices will receive a payment advice following each payment. This payment advice will outline practice and payment details.

Practices should routinely check their PNIP payment advice for accuracy.

Practices that make false or misleading claims or fail to notify Medicare Australia of any changes which affect their entitlement to PNIP payments may be required to repay any payments received incorrectly.

## Maintaining and changing practice information

### Notification of Changes

It is important that practices advise Medicare Australia of any changes in practice arrangements that may affect their eligibility for the PNIP. While practices generally have 14 calendar days in which to advise Medicare Australia of changes, practices need to make sure that this information is provided to Medicare Australia by the 'point in time' date. This will ensure that changes to practice arrangements are taken into account to accurately calculate the practice's next quarterly PNIP payment. When inaccurate information is used in the calculation process, the practice may not receive all of its entitled payments or alternatively any overpayments may be recovered by Medicare Australia. Relevant changes include, but are not limited to:

- changes in accreditation status such as the practice becoming fully accredited or accreditation lapsing;
- renewals or lapses in public liability cover or professional indemnity cover;
- changes to the bank account nominated for PNIP payments;
- changes to the authorised contact person(s) for the practice;
- changes to the practice location, ownership or structure;
- changes in the hours worked\* by Registered Nurses, Enrolled Nurses, Allied Health Workers (and allied health professionals where applicable);
- changes in provider numbers for any GPs at the practice; and or
- GPs leaving or joining the practice.

\* Hours worked refers to the standard or contracted hours for which the practice nurse is employed.

The General Practitioner Details and Declaration form will need to be submitted for each new GP that joins the practice.

Practices are able to make changes to the practice arrangements using the PNIP Online System. Practices that are unable to access the PNIP Online System must advise all changes in writing, on practice letterhead, signed by the authorised contact person, and witnessed by another person registered with the practice. Changes to practice details should be sent to:

Mail: **Practice Nurse Incentive Program**  
**GPO BOX 2572**  
**ADELAIDE SA 5001**

Fax: **1300 587 696**

Email: **pnip@medicareaustralia.gov.au**

Practices will also need to confirm their details contained in the quarterly confirmation statements.

### Quarterly Confirmation Statements

Medicare Australia will provide quarterly confirmation statements to all practices receiving the incentive payments, top-up payments and grandparenting payments each quarter prior to payment.

Practices will be required to confirm their details that are included on the quarterly confirmation statement before the payment can be released to the practice.

Practices will receive their quarterly confirmation statement via the PNIP Online system. Where a practice does not have access to the PNIP Online system, Medicare Australia will mail the confirmation statement.

If a practice does not complete the Quarterly Confirmation Statement by the point in time for eligibility assessment, the practice's payment will be withheld.

## Transferring the SWPE value of a practice

The general principles underpinning the transfer of a practice's SWPE value are that:

- wherever possible, the SWPE value remains with the location;
- where the SWPE value for a location may be transferred, it will be transferred in full or not at all; and
- the accreditation status of a practice does not affect the authority to transfer the SWPE value.

The only instances where the SWPE value of a practice may be transferred are outlined below.

## Amalgamations

For the purposes of the PNIP, the Department of Health and Ageing defines an amalgamation as:

“two or more practices coming together into one common location and sharing access to all patient records, belonging to each of the previously individual practices, **and** the closure of the remaining original location(s)”

The SWPE value of a practice may be transferred to the amalgamated practice when:

- the original and final locations of the amalgamating practices are within the local area; and
- another practice is not operating from any of the original location(s) at the 'point in time' following the amalgamation.

If the amalgamated practice meets the above requirements, the SWPE values of the original practices will be added together to form the new SWPE value of the amalgamated practice.

If the amalgamated practice does not meet these requirements, the practice will need to apply for the PNIP as a new practice and establish a SWPE value. However, if one (or more) of the amalgamating practices is situated outside the local area of the final location, the SWPE value of the practice originally on site at the final location is maintained.

If a SWPE value transfer has been approved and another practice has moved into the original location after the point in time for eligibility assessment, the practice operating from the original location will be required to establish a SWPE value.

## Relocation

The SWPE value of a practice may be transferred when a practice relocates if all the following criteria are met:

- the original and final locations are within the local area;
- another practice is not operating from the original location; and
- the patient base remains the same and all patient records are held with the relocated practice.

If the relocated practice does not meet these requirements, the practice will need to apply for the PNIP as a new practice, in its own right and establish a SWPE value.

## Change of Ownership

When there is a part or full change of ownership of a practice, the SWPE value of the practice remains with the location. It is the practice's responsibility to ensure that the SWPE value of the practice is taken into account in the sale price.

## Accreditation

Practices must be accredited, or registered for accreditation and achieve accreditation within 12 months of joining the PNIP, against the RACGP *Standards for general practices* to participate in the PNIP, and maintain full accreditation thereafter.

When an accredited PNIP practice amalgamates or relocates, it should contact its accrediting body to verify that the RACGP *Standards for general practices* continue to be met at the new location.

Practices transferring their accreditation status to a new location are required to provide evidence of this to Medicare Australia by the point in time eligibility assessment date following the relocation. Evidence must be in the form of an accreditation certificate issued by the accrediting body, which indicates the practice's new location address.

If evidence of transfer of accreditation status is not provided by the point in time eligibility assessment date following the relocation, the practice does not meet PNIP eligibility requirements and payments will be withheld. Withheld payments will only be released for the period that evidence of accreditation is produced. If payments are withheld for three consecutive payment quarters, the practice's entitlement to payments will cease. Practices must apply to rejoin the PNIP and be fully accredited to be eligible to participate.

If accreditation is not included in the sale of a practice, the practice is required to register for accreditation and provide evidence of this to Medicare Australia by the 'point in time' eligibility assessment date following the sale. If the new practice owners have not registered the practice for accreditation, the practice does not meet the PNIP eligibility requirements and payments will be withheld. If the practice is not registered for accreditation for three consecutive payment quarters, the practice's entitlement to payments will cease. The practice must then apply to rejoin the PNIP and be fully accredited to be eligible to participate.

Practices that are granted an extension to gain accreditation by an accrediting body must provide evidence of this to Medicare Australia to remain eligible for PNIP payments. Practices that do not provide Medicare Australia with evidence of an extension will have their payments withheld by Medicare Australia.

## Reinstatement

Practices that, either withdraw from PNIP or whose entitlement to payments cease due to ineligibility or non compliance, will need to reapply for the PNIP (excluding grandparenting). These practices will be treated as a new applicant. Such practices will also be required to be fully accredited to be eligible to participate.

## Grace Periods

Should a practice nurse, Aboriginal Health Worker or allied health professional (where applicable) leave a practice that is receiving funding from the PNIP, the practice will have 21 calendar days to replace the practice nurse, Aboriginal Health Worker or allied health professional (where applicable) before it will affect the calculation of incentives.

Should a practice nurse, Aboriginal Health Worker or allied health professional (where applicable) leave a practice that is receiving funding from PNIP and the practice meets one of the following criteria:

- the practice is receiving a rural loading based on the ASGC-RA classification;
- the practice is an Aboriginal Medical Service or Aboriginal Community Controlled Health Service; or
- the practice is in area of urban workforce shortage;

the practice will have 45 calendar days to replace the practice nurse, Aboriginal Health Worker or allied health professional (where applicable) before it will affect the calculation of their incentives.

If a practice is not able to replace the practice nurse, Aboriginal Health Worker or allied health professional (where applicable) within these timeframes, the practice has 14 calendar days to notify Medicare Australia of the change in their circumstances.

## Practice Nurse Incentive Program audit

Medicare Australia conducts audits of practices receiving payments under the PNIP payments to verify that practices are meeting the eligibility requirements. Audits may include practice visits or a review of practice documentation. If requested by Medicare Australia, practices must provide documentary evidence to support their eligibility and claims for payment.

## What are the obligations of the practice?

The practice must:

- be able to substantiate its claims for payments, including any relevant documentary evidence;
- provide information to Medicare Australia as part of its ongoing audit program to verify that the practice meets the PNIP eligibility requirements;
- make sure information provided to Medicare Australia is accurate; and
- advise Medicare Australia in writing of any changes to practice arrangements by the relevant 'point in time' or within 14 calendar days, whichever is earliest.

On joining the PNIP, the practice must nominate an authorised contact person(s), who will be required to verify on the practice's behalf, any changes to information submitted for PNIP claims and payments.

## Review of decision process

The PNIP has a review of decision process. To request a review of a decision, the authorised contact person or the owners of the practice must write to Medicare Australia within 28 calendar days of receiving notice of the decision it would like reviewed.

The request must include the following details:

- the name and address of the person requesting the review;
- the name and practice identification number of the practice;
- the decision to be reviewed; and
- the grounds for requesting the review

Medicare Australia will reconsider its decision in accordance with the PNIP eligibility criteria and/or payment formula used to make the original decision and advise the practice in writing of the outcome of the review.

If a practice is not satisfied with the reviewed decision, the practice may request the decision be considered by a Formal Review Committee. Further information for practices on the formal review process is available from the PNIP Enquiry Line on **1800 222 032**.

Medicare Australia may withhold a practice's quarterly payment where a review of decision process has been requested by the practice. Medicare Australia will make this decision on a case by case basis.

## More information

Application forms and additional information about the PNIP are available from Medicare Australia by visiting [www.medicareaustralia.gov.au/pnip](http://www.medicareaustralia.gov.au/pnip)

For more information about the PNIP email [pnip@medicareaustralia.gov.au](mailto:pnip@medicareaustralia.gov.au) or call **1800 222 032** (call charges may apply) between 8.30 am and 5.00 pm, Monday to Friday, Australian Central Standard Time (ACST).

These guidelines are for information purposes only. While it is presently intended that the Commonwealth will make payments as set out in these guidelines, the making of payments is at the sole discretion of the Commonwealth. The Commonwealth may alter arrangements for the PNIP at any time and without notice.

The Commonwealth does not accept any legal liability or responsibility for any injury, loss or damage incurred by the use of, reliance on or interpretation of the information provided in these guidelines.

# Practice Nurse Incentive Program Guidelines

June 2011

Examples of payment calculations

## \*These scenarios are for illustration purposes only.

The following table shows the incentive amounts to be paid based on specific SWPE values. Practice should note that payments will be based on a practice's actual SWPE values and the incentive amount adjusted accordingly.

SWPE	Minimum number of practice nurse hours per week required for full incentive payment	Incentive Amount for a Registered Nurse (or allied health professional, where applicable)	Incentive Amount for an Enrolled Nurse or Aboriginal Health Worker
1,000	12 hours 40 minutes	\$25,000	\$12,500
2,000	25 hours 20 minutes	\$50,000	\$25,000
3,000	38 hours	\$75,000	\$37,500
4,000	50 hours 40 minutes	\$100,000	\$50,000
5,000	63 hours 20 minutes	\$125,000	\$62,500

The following scenarios have been calculated using the ready reckoner that is also available on Medicare Australia's website.

### Scenario 1

The Redtown Family Practice is an accredited general practice that has a SWPE value of 3,000. The practice employs a practice nurse (a Registered Nurse (RN)) for 38 hours per week.

The Redtown Family Practice would be eligible for a full RN incentive totalling \$75,000 per annum or \$18,750 per quarter.

### Scenario 2

The Bluetown General Practice has a SWPE value of 3,000 but employs a RN for 19 hours per week and an Enrolled Nurse (EN) for 19 hours per week.

The Bluetown General Practice would be eligible for half of the RN full incentive amount (\$37,500) and half of the EN full incentive amount (\$18,750) totalling \$56,250 per annum or \$14,062.50 per quarter.

### Scenario 3

Across the city, there is a larger general practice called the Purpletown Family Practice which has a SWPE value of 5,000. The Purpletown Family Practice only has one RN who works 38 hours per week.

Even though the Purpletown Family Practice has a SWPE value of 5,000, it would only be eligible for an incentive based on one full time practice nurse. The incentive would be equivalent to one RN incentive being \$75,000 per annum or \$18,750 per quarter.

### Scenario 4

The Greentown General Practice is in a rural location which is considered RA3 Outer Regional area. A 30% loading is applied to this practice's incentive as it is in a RA3 location. Greentown General Practice has a SWPE value of 2,000 and two RNs who job share working 25 hours 20 minutes per week between them.

The Greentown General Practice would be eligible for an incentive of \$50,000 per annum which would then have the rural loading applied. The total amount to be paid to the Greentown General Practice would be \$65,000 per annum or \$16,250 per quarter.

### Scenario 5

An Aboriginal Medical Service which would have its SWPE value increased by 50% is in a RA3 Outer Regional area. A 30% loading is applied to this practice's incentive as it is in a RA3 location.

The Aboriginal Medical Service has a SWPE value of 2,000 and 3 Aboriginal Health Worker who each work 38 hours per week. The Aboriginal Medical Service SWPE value would be increased by 50% to 3,000.

The Aboriginal Medical Service would be eligible for an incentive of \$37,500 per annum which would then have the rural loading applied. The total amount to be paid to the Aboriginal Medical Service would be \$48,750 per annum or \$12,187.50 per quarter.

## Scenario 6

The Greytown General Practice employs 15 GPs working various hours but has a SWPE value of 7,250 and employs 3 practice nurses for 55 hours per week. (2 RNs working 20 hours per week each and 1 EN working 15 hours per week).

The SWPE value for the Greytown General Practice would be capped at 5,000 and the practice would be eligible for a payment totalling \$93,750 per annum or \$23,438 per quarter.

## Scenario 7

The Pinktown General Practice employs 7 GPs working various hours but has a SWPE value of 5,456 and employs 2 RNs for a total of 69 hours per week.

The SWPE value for the Pinktown General Practice would be capped at 5,000 and the practice would be eligible for the maximum payment of \$125,000 per annum or \$31,250 per quarter.

## Scenario 8

### Example of top-up payment where the practice maintains the same practice nurse hours in the payment quarter as in the historical period quarter

The Whitetown General Practice is accredited and prior to the introduction of the Practice Nurse Incentive Program it has been using the MBS practice nurse items\* and receiving the PIP Practice Nurse Incentive. During the historical period (1 August 2010 to 31 July 2011) the Whitetown General Practice received \$117,000 in payments for the MBS practice nurse items and the PIP Practice Nurse Incentive.

During the historical period and each payment quarter the practice has two RNs who work a total of 50 hours 40 minutes per week. The Whitetown General Practice has a SWPE value of 4,000. Based on this information, the Whitetown General Practice would be eligible for an incentive of \$100,000 per annum or \$25,000 per quarter under the Practice Nurse Incentive Program.

With the GPs' consent, the Whitetown General Practice has provided Medicare Australia with details of the GPs at the practice during the historical period. Medicare Australia uses this information to assess if the practice is financially disadvantaged by the introduction of the Practice Nurse Incentive Program.

Where the value of the MBS practice nurse items and the PIP Practice Nurse Incentive for the historical period quarter is greater than the value of incentives in the payment quarter a top-up payment will be made to the practice for that quarter. These arrangements will continue for the first three years of the Practice Nurse Incentive Program.

For the first three years of the program, the Whitetown General Practice's practice nurse workforce remains exactly the same during the payment quarters (RNs for 50 hours 40 minutes per week) as in the historical period quarters.

The table below explains how the top-up payment is calculated for this situation.

\*Note: the MBS practice nurse items removed are 10993, 10994, 10995, 10996, 10998, and 10999

Scenario 8 Table

	Quarter 1 (1 November – 31 January)	Quarter 2 (1 February – 30 April)	Quarter 3 (1 May – 31 July)	Quarter 4 (1 August – 31 October)	Annual Total
Historical period quarters	1 November 2010 – 31 January 2011	1 February 2011 – 30 April 2011	1 May 2011 – 31 July 2011	1 August 2010 – 31 October 2010	
Combined MBS Practice Nurse items & PIP Practice Nurse Incentive - historical period	\$25,000	\$32,000	\$33,000	\$27,000	\$117,000
Contracted Practice Nurse hrs/week - historical period	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	
Contracted Practice Nurse hrs/week - payment quarter	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	
MBS Practice Nurse items and PIP Practice Nurse Incentive: adjusted for nurse hr changes (A)	\$25,000 (no adjustment)	\$32,000 (no adjustment)	\$33,000 (no adjustment)	\$27,000 (no adjustment)	\$117,000
PNIP Incentive Payment (B)	\$25,000	\$25,000	\$25,000	\$25,000	\$100,000
Top up amount (C = A-B)	\$0	\$7,000	\$8,000	\$2,000	\$17,000
Total payment (C+B)	\$25,000	\$32,000	\$33,000	\$27,000	\$117,000

## Scenario 9

### Example of top-up payment where the practice does not maintain the same practice nurse workforce in the payment quarters as those in the historical period quarter

The Orangetown General Practice is accredited and prior to the introduction of the Practice Nurse Incentive Program it has been using the MBS practice nurse items\* and receiving the PIP Practice Nurse Incentive. During the historical period (1 August 2010 to 31 July 2011) the Whitetown General Practice received \$117,000 in payments for the MBS practice nurse items and the PIP Practice Nurse Incentive.

During the historical period the practice has two RNs who work a total of 50 hours 40 minutes per week. The number of hours the RNs are contracted to work during the payment quarters varies (as detailed in the table below). The Whitetown General Practice has a SWPE value of 4,000. The incentive the Whitetown General Practice is eligible for each payment quarter is detailed below.

With the GPs' consent, the Whitetown General Practice has provided Medicare Australia with details of the GPs at the practice during the historical period. Medicare Australia will use this information to assess if the practice is financially disadvantaged by the introduction of the Practice Nurse Incentive Program. Where the value of the MBS practice nurse items and the PIP Practice Nurse Incentive for the historical period quarter is greater than the value of incentives in the payment quarter a top-up payment will be made to the practice for that quarter. These arrangements will continue for the first three years of the Practice Nurse Incentive Program.

The table below explains how the top-up payment is calculated in the situation where the practice's nurse workforce varies over the payment quarters.

\*Note: the MBS practice nurse items removed are 10993, 10994, 10995, 10996, 10998, and 10999

#### Scenario 9 Table

	Quarter 1 (1 November – 31 January)	Quarter 2 (1 February – 30 April)	Quarter 3 (1 May – 31 July)	Quarter 4 (1 August – 31 October)	Annual Total
Historical period quarters	1 November 2010 – 31 January 2011	1 February 2011 – 30 April 2011	1 May 2011 – 31 July 2011	1 August 2010 – 31 October 2010	
Combined MBS Practice Nurse items & PIP Practice Nurse Incentive - historical period	\$25,000	\$32,000	\$33,000	\$27,000	\$117,000
Contracted Practice Nurse hrs/week - historical period	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	
Contracted Practice Nurse hrs/week - payment quarter	RN – 40 hrs 32 min (- 20%)	RN – 40 hrs 32 min (-20%)	RN – 63 hrs 48 min (+20%)	RN – 50 hrs 40 min	
MBS Practice Nurse items and PIP Practice Nurse Incentive: adjusted for nurse hr changes (A)	\$20,000 (- 20%)	\$25,600 (- 20%)	\$33,000 (no adjustment)	\$27,000 (no adjustment)	\$105,600
PNIP Incentive Payment (B)	\$20,000	\$20,000	\$25,000	\$25,000	\$90,000
Top up amount (C = A-B)	\$0	\$5,600	\$8,000	\$2,000	\$15,600
Total payment (C+B)	\$20,000	\$25,600	\$33,000	\$27,000	\$105,600

## Scenario 10

### Example of grandparenting payment where a practice maintains its practice nurse workforce

The Orangetown General Practice is a non-accredited practice and prior to the introduction of the Practice Nurse Incentive Program it has been using the MBS practice nurse items\*. During the historical period (1 August 2010 to 31 July 2011) the Orangetown General Practice received \$117,000 in payments for the MBS practice nurse items.

During the historical period and for each payment quarter the practice has two RNs who work a total of 50 hours 40 minutes per week.

With the GPs' consent, the practice has provided Medicare Australia with details of the GPs at the practice during the historical period. Medicare Australia uses this information to assess if the practice is financially disadvantaged by the introduction of the Practice Nurse Incentive Program. The Orangetown General Practice would be eligible to receive a grandparenting payment for the first three years of the program.

The Orangetown General Practice's practice nurse workforce was exactly the same during the payment quarters as that in the historical period quarters.

The table below explains how the grandparenting payment is calculated for the Orangetown General Practice.

\*Note: the MBS practice nurse items removed are 10993, 10994, 10995, 10996, 10998, and 10999

## Scenario 10 Table

	Quarter 1 (1 November – 31 January)	Quarter 2 (1 February – 30 April)	Quarter 3 (1 May – 31 July)	Quarter 4 (1 August – 31 October)	Annual Total
Historical period quarters	1 November 2010 – 31 January 2011	1 February 2011 – 30 April 2011	1 May 2011 – 31 July 2011	1 August 2010 – 31 October 2010	
MBS Practice Nurse items - historical period	\$25,000	\$32,000	\$33,000	\$27,000	\$117,000
Contracted Practice Nurse hrs/week - historical period	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	
Contracted Practice Nurse hrs/week - payment quarter	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	
MBS Practice Nurse items adjusted for nurse hr changes	\$25,000 (no adjustment)	\$32,000 (no adjustment)	\$33,000 (no adjustment)	\$27,000 (no adjustment)	\$117,000
Grandparenting payment	\$25,000	\$32,000	\$33,000	\$27,000	\$117,000

## Scenario 11

### Example of grandparenting payment were a practice does not maintain its practice nurse workforce in the payment quarters as in the historical quarter

The Orangetown General Practice is a non-accredited practice and prior to the introduction of the Practice Nurse Incentive Program it has been using the MBS practice nurse items\*. During the historical period (1 August 2010 to 31 July 2011) the Orangetown General Practice received \$117,000 in payments for the MBS practice nurse items.

During the historical period the practice has two RNs who work a total of 50 hours 40 minutes per week. The number of hours the RNs are contracted to work during the payment quarters varies and are detailed in the table below.

With the GPs' consent, the practice has provided Medicare Australia with details of the GPs at the practice during the historical period. Medicare Australia uses this information to assess if the practice is financially disadvantaged by the introduction of the Practice Nurse Incentive Program. The Orangetown General Practice would be eligible to receive a grandparenting payment for the first three years of the program.

The table below explains how the top-up payment is calculated in the situation where the practice's nurse workforce varies over the payment quarters.

\*Note: the MBS practice nurse items removed are 10993, 10994, 10995, 10996, 10998, and 10999

## Scenario 11 Table

	Quarter 1 (1 November – 31 January)	Quarter 2 (1 February – 30 April)	Quarter 3 (1 May – 31 July)	Quarter 4 (1 August – 31 October)	Annual Total
Historical period quarters	1 November 2010 – 31 January 2011	1 February 2011 – 30 April 2011	1 May 2011 – 31 July 2011	1 August 2010 – 31 October 2010	
MBS Practice Nurse items - historical period	\$25,000	\$32,000	\$33,000	\$27,000	\$117,000
Contracted Practice Nurse hrs/week - historical period	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	RN – 50 hrs 40 min	
Contracted Practice Nurse hrs/week - payment quarter	RN – 40 hrs 32 min (-20%)	RN – 40 hrs 32 min (-20%)	RN – 63 hrs 48 min (+20%)	RN – 50 hrs 40 min	
MBS Practice Nurse items adjusted for nurse hr changes	\$20,000 (-20%)	\$25,600 (-20%)	\$33,000 (no adjustment )	\$27,000 (no adjustment)	\$105,600
Grandparenting payment	\$20,000	\$25,600	\$33,000	\$27,000	\$105,600

# Practice Nurse Incentive Program Guidelines

June 2011

## Role for nurses in general practice settings

Nurses are recognised as effective and accountable providers of health care by both health professionals and the general community. They are valued as respected members of a coordinated and effective team based approach to patient care.

Nurses who are employed in general practice may be Registered Nurses, Enrolled Nurses, Nurse Practitioners and Midwives. Aboriginal Health Workers and allied health professionals may also be employed in general practice. These health professionals employed in general practice provide services on behalf of the medical practitioners working within a medical practice.

**Participating** midwives and nurse practitioners (ie those billing the MBS, see definitions section below) are non referred health practitioners and while they may work and be employed in a general practice, they provide Medicare rebateable services in their own right, and so cannot participate in the Practice Nurse Incentive Program (PNIP).<sup>1</sup>

### Describing the role of nurses in general practice

The role of the nurse in general practice is diverse, may vary between general practices and is influenced by factors such as the:

- Nurse's skills, qualifications, experience, access to professional networks, continuing education and professional supports;
- Population profile and structure of the general practice, including scope, resources and reach (eg types of services delivered and outreach); and
- General practice management, culture, values and attitude.

Nurses in general practice work to professional standards which have been defined for the general practice setting but are based on the more general professional competency standards for the Registered and Enrolled nurse. The areas of practice identified below are adapted from the competency standards for the general practice nurse ([www.anf.org.au/nurses\\_gp](http://www.anf.org.au/nurses_gp)).

### Definitions

- Registered Nurse (RN): a person who has undertaken a Bachelor level nursing education program and is licensed to practise with the Nursing and Midwifery Board of Australia.<sup>2</sup>
- Enrolled Nurse (EN): a person who has undertaken a Certificate IV or Diploma level nursing program (usually in the vocational education setting) and is licensed to practise with the Nursing and Midwifery Board of Australia to provide nursing care under the supervision of a Registered Nurse.<sup>2</sup>
- A participating midwife is an eligible midwife who renders a Medicare rebateable service in a collaborative arrangement or collaborative arrangements of a kind or kinds specified in the regulations, with one or more medical practitioners, of a kind or kinds specified in the regulations.<sup>3</sup>
- A participating nurse practitioner is an eligible nurse practitioner who has obtained a minimum of a Masters level of qualification and who renders a Medicare rebateable service in a collaborative arrangement or collaborative arrangements of a kind or kinds specified in the regulations, with one or more medical practitioner/s, of a kind or kinds specified in the regulations.<sup>3</sup>

### Supervision of the Enrolled Nurse

The enrolled nurse is legally required to be supervised by a registered nurse and is accountable and responsible for all aspects of delegated care.<sup>4</sup> Enrolled nurses are expected to provide care as part of the health care team under the supervision and direction of the registered nurse.<sup>5</sup> Registered nurses may supervise and direct enrolled nurses directly or indirectly:

- Direct supervision is when the RN is present and observes, works with and directs the EN. This involves the RN and EN being based at the same practice.
- Indirect supervision is when the RN is easily contactable but does not directly observe the activities of the EN. This requires processes being in place for the direction, guidance, support and monitoring of the EN's activities. The RN is required to observe and assess the EN's competence prior to entering into an indirect supervisory arrangement. The RN may be located offsite, however must be available for regular direct communication through a structured arrangement.

### The role of nurses in general practice

While this document provides an outline of the role a practice nurse can have in general practice, it is not an exhaustive list. The role of nurses varies considerably across general practice and this flexibility allows practices to best meet the needs of their patient population.

## 1. Professional practice

Nurses in general practice can contribute to the planning and delivery of care for the practice population based on an understanding of professional, legal and ethical standards.<sup>5</sup>

The role of nurses varies across general practice, and may include, but is not limited to:

- Participating in practice planning, clinical team meetings, influencing clinical service planning, development, delivery and innovation.
- Participating in / leading a team approach to managing adverse events.
- Development and analysis of population health data, including developing and monitoring disease registers.
- Undertaking professional development to ensure ongoing competence and knowledge of current best practice.
- Educating other members of the general practice team, as appropriate, on issues such as:
  - » New or emerging practice with a focus on evidence-based practice
  - » Quality and safety in practice
  - » Collaborative practice within a multidisciplinary team
  - » Workplace health and safety
  - » Practice procedures and systems.
- Practising and promoting Cultural Respect – the recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples.<sup>6,7</sup>
- Reactive and strategic problem solving and agent of change to improve systems or processes in the practice.
- Clinical systems management – updates practice and clinical policies and procedures and develops/maintains clinical reports.

## 2. Provision and coordination of clinical care

RNs in general practice have the knowledge, skills and education to provide comprehensive, episodic interventions and population based primary health care. ENs have the knowledge and skill to provide care delegated by a registered nurse.<sup>3</sup>

The role of nurses varies across general practice, and may include, but is not limited to:

*Provision of clinical nursing services through:*

- Triage.
- Emergency management.
- Holistic health assessment including patient history, health screening, and physical and preventative health checks - eg immunisation, cervical smears, child health checks, oral health checks, managing recall and reminders system and disease monitoring of individuals and communities.
- Participating in the preparation of GP Management Plans and Team Care Arrangements and their review.
- Therapeutic care and treatment – participating in / leading a team approach to chronic disease management, wound management, first aid, oral health checks, assistance with minor surgical procedures, administration of oral or injectable medications and vaccines and clinical procedures.
- Diagnostic services – ECGs, stress tests, urine drug screening, hearing tests, peak flow, spirometry and mood & memory assessment.

*Promoting patient, family, carer and community wellbeing through:*

- Patient audit and recruitment.
- Community development including promotion of healthy lifestyle and liaison with community groups.
- Self care and self-management – provision of patient/carer education, information and support, health coaching and assisting patients to navigate the health system.

- Educating patients in areas of, but not limited to:
  - » Prevention and health promotion
  - » Management of specific health conditions including asthma and diabetes
  - » Women's health checks and Pap smears
  - » Immunisation programs including childhood immunisation
  - » Participating in local and/or national disease prevention campaigns (e.g. Influenza)
  - » Domestic violence, quit smoking, drug and alcohol guidance, advice and/or support
  - » Support for weight reduction through provision of exercise and dietary information
  - » Maternal and child health including antenatal care and well baby checks.

*Improving health outcomes through:*

- Outreach services – eg home visits, medication administration, first aid, health promotion and family planning advice.
- Supporting the development of electronic health communications.
- Sharing patient information as appropriate – providing a patient's medical record to the relevant hospital after admission and including discharge summaries on patient's file.
- Care coordination and monitoring of acute and chronic disease.
- Nurse led clinics – RNs with advanced skills may also conduct nurse led clinics eg maternal and child health, education and monitoring of various conditions.

### **3. Management of clinical care systems**

Nurses in general practice develop, coordinate and administer systems and processes which assist the general practice team to anticipate and manage health care interventions, mediate risk and facilitate quality care outcomes.<sup>5</sup>

The role of nurses varies across general practice, and may include, but is not limited to:

- Maintaining, monitoring and improving patient information systems including the patient register and recall systems.
- Practice population profiling – collecting and analysing information, including Aboriginality, to inform health promotion and illness prevention strategies and to improve systems and quality care.
- Arranging patient follow up of pathology results with evidence of audit trails.
- Follow up of specialists' appointments or other referrals for patients.
- Leading / supporting practice accreditation.
- Leading / ensuring compliance with occupational health and safety systems.
- Implementing clinical risk systems.
- Ensuring maintenance of cold chain for vaccines.
- Stock control including drugs and compliance with various drug Acts.
- Cleaning and sterilisation of instruments in accordance with industry standards, thus minimising risk of health care acquired infections.

Nurses in general practice can also play a role in sustaining general practice by:

- Building practice capacity – optimising the use of professional resources through effective utilisation of practice nurses to undertake a broader range of tasks.
- Building the practice base – provision of multi-disciplinary team based care.
- Building practice capacity to adapt to change – enhanced use of the multi-disciplinary team to better support older patients, those with chronic disease, and address patient expectations.

#### 4. Collaborative practice

Nurses in general practice build and engage in a broad range of collaborative relationships with the general practice team and other health care and service providers to support positive outcomes for patients and the community.<sup>5</sup>

The role of nurses varies across general practice, and may include, but is not limited to:

- Identifying and understanding the role of community agencies and service providers and networking with these services.
- Liaising with Local Hospital Networks and other health service providers to enable smooth transfer of client care between health care sectors – including, but not limited to: acute and sub-acute care, aged care, community care and primary health care.
- Building and maintaining relationships across the practice team, including providing support and actively responding to requests from other members of the general practice team.
- Integrating service delivery including arranging appointments, managing internal and external referral processes and procedures, scanning results, arranging case conferences and providing information and feedback between the services, patients and GP.
- Planning and coordinating care including routine monitoring and follow up of patients with care plans.
- Patient advocacy.

#### Further information

Additional information about the role for nurses in general practice can be found at:

Australian Practice Nurse Association (APNA) ([www.apna.asn.au](http://www.apna.asn.au))

Australian General Practice Network (AGPN) – Nursing in General Practice (<http://generalpracticenursing.com.au/>)

Australian Nursing Federation. 2011. Fact Sheet: A snapshot of practice nurses in Australia.

Available at: [http://www.anf.org.au/pdf/Fact\\_Sheet\\_Snap\\_Shot\\_General\\_Practice\\_Nurses.pdf](http://www.anf.org.au/pdf/Fact_Sheet_Snap_Shot_General_Practice_Nurses.pdf)

Australian Nursing Federation – Competency Standards [http://www.anf.org.au/html/publications\\_compstandards.html](http://www.anf.org.au/html/publications_compstandards.html)

Department of Health and Ageing – Nursing in General Practice - education and training.

Available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/work-pr-nigp>

Royal College of Nursing Australia (RCNA) – *Nursing in General Practice - a guide for the general practice team.*

Available at: <http://www.rcna.org.au/publications/Nursing-in-General-Practice.pdf>

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<sup>1</sup> From 1 November 2010 eligible Midwives and Nurse Practitioners have access to the Medicare arrangements which include providing Medicare rebateable services, referrals to medical specialists and requesting certain diagnostic services. Nurse Practitioners will also be able to request pathology and diagnostic services and refer patients to specialist and consultant physicians within their scope of practice.

<sup>2</sup> Adapted from: Royal College of Nursing Australia. 2005. *Nursing in General Practice. A Guide for the General Practice Team.*

<sup>3</sup> Health Insurance Act 1973.

<sup>4</sup> Australian Nursing Federation, 2005. *Competency Standards for nurses in general practice.* ANF, Canberra.

<sup>5</sup> Australian Nursing and Midwifery Council (ANMC) 2002. *National Competency Standards for the Enrolled Nurse.* ANMC, Canberra.  
Available at: <http://www.capdivgp.com/content/Document/Practice%20Nurses/Competency%2520standards%2520EN.pdf>

<sup>6</sup> AHMAC Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009, Australian Health Ministers' Advisory Council available at [www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-crf.htm/\\$FILE/Cultural\\_Respect\\_Framework.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-crf.htm/$FILE/Cultural_Respect_Framework.pdf)

<sup>7</sup> Thackrah, R. and Scott, K. (2011) *Indigenous Australian health and cultures. An introduction for health professionals.* Sydney: Pearson