Practice Nurse Incentive Program Guidelines - July 2012

Introduction

The Practice Nurse Incentive Program (PNIP) began 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 a payment to help with the costs of employing a practice nurse. One of the eligibility requirements is the practice must be accredited under the current Royal Australian College of General Practitioners (RACGP) *Standards for general practices*.

The PNIP also includes:

- 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 of workforce shortage, 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 per cent based on Australian Standard Geographical Classification—Remoteness Areas (ASGC-RA)
- a one-off $5000 incentive to support eligible non-accredited practices to become accredited
- grandparenting arrangements for the first three years of the program to make sure that practices are not financially disadvantaged by the restructure of the Practice Incentives Program (PIP) 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 practitioner (GP) services to Department of Veterans' Affairs (DVA) Gold Card holders.

The PNIP simplifies financing arrangements by combining funding from the previous PIP Practice Nurse Incentive and MBS practice nurse items and replacing them with a single payment.

The following MBS practice nurse items covering immunisation, cervical smears and treatment of a person's wound have been removed:

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

The PNIP is administered by the Department of Human Services (Human Services) on behalf of the Department of Health and Ageing (DoHA) and DVA.

These guidelines explain how to apply for payments under the PNIP and how the arrangements will work.

Attachment A contains a number of different payment calculation scenarios.

Payments under the PNIP are paid to eligible general practices that apply. Practices not eligible for incentive payments under the PNIP may be eligible for the grandparenting payment if they are financially disadvantaged by the removal of six of the MBS practice nurse items and associated Bulk Billing Incentive (BBI) items.

The level of incentive payment is dependent on the practice's Standardised Whole Patient Equivalent (SWPE) value and the number of hours worked by practice nurses. More information on calculating a practice's SWPE value and practice nurse hours can be found in the **Payments section**.

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
- have current public liability insurance
- make sure that all practice GPs have current professional indemnity cover
- make sure that all practice nurses, Aboriginal Health Workers and allied health professionals are covered by appropriate professional indemnity insurance arrangements as required by the Australian 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 can include less than one full time GP (for example, a GP who works part-time).

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

- registered nurses
- enrolled nurses, and/or
- Aboriginal Health Workers.

Practices are not eligible for PNIP incentives for any hours they are supported to employ or retain the services of a practice nurse, Aboriginal Health Worker or allied health professional through:

- Australian, State or Territory Government funding
- other private funding, or
- incentive programs (for example, the Mental Health Nurse Incentive Program).

This restriction doesn't apply where the funding for these health professionals has been provided by the Office for Aboriginal and Torres Strait Islander Health.

Practices that employ an Aboriginal Health Worker or allied health professional with their own provider number are not eligible for PNIP incentives for any time that those health professionals spend on the relevant MBS services.

This doesn't apply to Aboriginal Medical Services, Aboriginal Community Controlled Health Services and State/Territory Government health clinics that have an exemption under Section 19(2) of the *Health Insurance Act 1973* or that receive funding for Aboriginal Health Workers or allied health professionals through the Office of Aboriginal and Torres Strait Islander Health.

Practices in urban areas of workforce shortage as well as Aboriginal Medical Services and 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 DoHA.

Minimum qualifications of practice nurses and health professionals

Registered nurses and enrolled nurses

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 their work.

Professional nursing standards require an enrolled nurse to be supervised by a registered nurse. Supervision may be direct or indirect, but appropriate supervisory arrangements must be in place.

For more information see **Attachment B—Roles for nurses in general practice settings.**

Aboriginal Health Workers

Aboriginal Health Workers must hold a *Certificate Level III* or above in Aboriginal and Torres Strait Islander Health from a recognised institute.

For a comprehensive list of approved courses and training for Aboriginal Health Workers, email pnip@humanservices.gov.au or call **1800 222 032*** 8.30 am to 5.00 pm, Monday to Friday, Australia Central Standard Time.

Allied health professionals

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

How does my practice apply for the PNIP?

Practices can apply for the PNIP through PNIP Online. PNIP Online is available through Health Professional Online Services (HPOS).

Practice owners and authorised contact persons must have a Public Key Infrastructure (PKI) individual certificate to access HPOS. To register for a PKI individual certificate, complete an application form available from **humanservices.gov.au/healthprofessionals** then Doing business with Medicare > Online business > Register > Applying for certificates or call the eBusiness Service Centre on **1800 700 199***.

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

Practice and GP information is kept secure by limiting system access only to people 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 details.

Practices can also apply to join the PNIP using the *PNIP Application* form which is available at **humanservices.gov.au/healthprofessionals** then **Incentives and Allowances > Practice Nurse Incentive Program**.

Human Services will assess applications and let applicants know, in writing, of their eligibility.

- Only the practice 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).
- The contact person(s) must be authorised by the owner(s) of the practice to advise Human Services of any changes and will be the person(s) who all correspondence or enquiries are sent to.
- Human Services can only contact the current owner(s) or authorised contact persons(s).

Privacy and consent

The PNIP needs practices and GPs to give their consent for a number of program components.

Any practice participating in the PIP can consent to Human Services using its practice information, including its SWPE for the purposes of PNIP.

GPs at the practice also need to give consent for Human Services to use their MBS billing data or service data for some PNIP calculations.

Human Services can't use information supplied for the PIP for the purposes of the PNIP without consent as this would breach the obligations outlined under Section 14—*Information Privacy Principles* of the *Privacy Act 1988* (the Act), specifically *Principle 2—Solicitation of personal information from the individual concerned* (IPP2) and *Principle 10—Limits on use of personal information* (IPP10).

Consent from a PIP practice

Giving consent means the PNIP can use the practice's:

- SWPE already in use for the PIP, and
- details provided for the PIP including:
    - practice name and main address

- eligibility details such as accreditation, public liability insurance and indemnity insurance
- bank account details
- contact details
- location details
- ownership details
- GP summary details (name and provider number only—excludes provider consent)
- associated documents, and
- comments.

The PNIP Online application process will auto fill all these details including summary details of the current GPs.

The use of provider information to calculate the PIP SWPE is summarised at practice level—the provider can't be identified. Therefore provider consent is not needed to use the practice SWPE.

GP consent

Annual DVA loading

A GP must provide consent for their MBS service data, for services provided to DVA Gold Card holders, to be included in the calculation of the practice's annual DVA loading.

If the GP doesn't provide consent, those DVA services can't be included in the calculation of the DVA loading.

Non-PIP registered practice

A practice that isn't registered for PIP will need to provide the consent of its current GPs to use their data in the PNIP SWPE calculation. The SWPE value impacts the level of incentive payment the practice will receive.

If a GP doesn't consent, the practice's PNIP SWPE will be based only on the GPs who have provided consent for the use of their MBS billing data.

Quarterly Confirmation Statements

If a GP does not provide consent they will not be listed on the practice's Quarterly Confirmation Statements (QCS).

What evidence does my practice need to provide when applying for PNIP?

Practices need to provide the following evidence:

- a certificate of accreditation or registration for accreditation, or other documentation, from the accreditation body
- proof the practice employs or otherwise retains the services of a practice nurse, Aboriginal Health Worker or allied health professional. This will be confirmed by a letter at the time of application and in the QCS

proof the practice employs or otherwise retains the services of a GP—confirmed in the Individual General Practitioner details and declaration section of the *PNIP Application* form, and

- if the practice employs an enrolled nurse, proof they employ or otherwise retain the services of a registered nurse to supervise the enrolled nurse. This will be confirmed by a letter at the time of

application and in the QCS. The hours worked by the supervising registered nurse need to be noted on the practice's application form.

Practices can submit the evidence as an attachment to their application through HPOS. Practices can also mail or fax the documentation. Make sure practice details are clearly visible on the application form and evidence and submit to:

Mail: Practice Nurse Incentive Program

Department of Human Services

GPO BOX 2572

ADELAIDE SA 5001

Fax: 1300 587 696*

Human Services will assess completed applications and let applicants know, in writing, if they're eligible.

Additional requirements

Practices must be able to prove the following if asked by Human Services:

- appropriate insurance coverage, including:
  - public liability insurance cover
  - professional indemnity cover for GPs, and
  - appropriate professional indemnity insurance for all practice nurses, Aboriginal Health Workers and allied health professionals as required by the Australian Health Practitioner Regulation Agency or by the professional's registration body
- 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 can apply for the PNIP as a single practice as long as the eligibility requirements are met. Practices need to nominate the main practice location. The main practice location should be the practice location that provides the highest number of MBS services each year. Additional practice locations are known as practice branches.

Eligibility requirements

To be considered eligible as a practice branch:

- 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 3000 services each year 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 3000 or more services each year 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.

Payments

Incentive payments

Payments under the PNIP are calculated quarterly with one incentive equating to:

- $25 000 per year, per 1000 SWPE where a registered nurse works at least 12 hours 40 minutes per week, and
- $12 500 per year, per 1000 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 year, per 1000 SWPE to employ or otherwise retain the services of an eligible allied health professional who works 12 hours 40 minutes per week. Human Services will let a practice know 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, Aboriginal Health Workers and allied health professionals. If a practice uses the services of registered nurses, enrolled nurses, Aboriginal Health Workers and/or allied health professionals the higher incentive of $25 000 will be applied first.

Rural loading

A rural loading will be applied to each incentive (or part thereof) for which the 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.

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. Practices will need to calculate the total hours per week for all registered nurses, enrolled nurses, Aboriginal Health

Workers and allied health professionals working at the practice. The total hours per week are the standard agreed weekly hours as set out in the employment contract.

More information on the restrictions that apply when a practice is in receipt of other funding can be found under **Is my practice eligible?**

Calculation of a full time GP

For the purposes of the PNIP, the calculation of a full-time GP is based on a practice's SWPE value. As a guide, the average full-time GP has a SWPE value of around 1000 SWPEs each year. Human Services will determine a practice's SWPE value based on MBS data of the GPs working in the practice.

Where a practice has a SWPE value of less than 1000 or does not have the minimum number of practice nurse hours per week, it will receive a proportionate payment.

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

Example

A practice with a SWPE value of 1200 will receive 1.2 incentives, if it employs or otherwise retains the services of a practice nurse, Aboriginal Health Worker or allied health professional who works at least 15 hours 12 minutes (1.2 x 12 hours 40 minutes) per week. If the practice has a registered nurse working for 15 hours 12 minutes, this would result in a payment of $30 000 per year or $7500 per quarter.

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

SWPE	Minimum number of practice nurse hours per week for full incentive payment	Incentive amount for a registered nurse or allied health professional	Incentive amount for an enrolled nurse[#] or Aboriginal Health Worker
1000	12 hours 40 minutes	$25 000	$12 500
2000	25 hours 20 minutes	$50 000	$25 000
3000	38 hours	$75 000	$37 500
4000	50 hours 40 minutes	$100 000	$50 000
5000	63 hours 20 minutes	$125 000	$62 500

[#] Where applicable.

Calculating the SWPE value

The SWPE value of a practice is the sum of the fractions and is based on the amount of care provided to patients, weighted for the age and gender of each patient. As a guide, the average full-time GP has a SWPE value of around 1000 SWPEs each year. 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 ÷ $500 or 0.2 of the patient's care.
- Practice B would be assigned with $400 ÷ $500 or 0.8 of the patient's care.

The total care for each patient equals one (1.0) and is known as the 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 recognises that people need 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 at **humanservices.gov.au/healthprofessionals**.

3. Total the SWPE

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

Practices without an historical SWPE

New practices and practices not participating in the PIP will not have a historical SWPE value and will be given a start up SWPE value of 1000. Practices that do not consent to the use of their PIP data will also receive a start-up SWPE value of 1000.

It takes approximately six PNIP payment quarters to establish a full SWPE value. The SWPE value will then be used, even if it is lower than 1000. If the practice's SWPE value is more than 1000, 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 per cent.

What if my practice is financially disadvantaged by the PNIP?

If a practice is assessed as being financially disadvantaged by the introduction of the PNIP, payments will be made to the practice until 31 December 2014 to address the disadvantage. Applications for financial disadvantage closed on 30 June 2012.

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

Top-up payments will be available for the first three years of the PNIP to make sure accredited practices (or practices that are registered for accreditation) are not financially disadvantaged by the removal of the PIP Practice Nurse Incentive and/or the six MBS practice nurse items plus any associated BBI items. Top-up payments will be paid until 31 December 2014. Applications for top-up payments closed on 30 June 2012.

Practices in this situation may be provided with a top-up payment, in addition to the PNIP incentive payments. The top-up amount is the difference between the amount(s) received under practice nurse income 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 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. These hours must be maintained in order for the practice to receive the maximum top-up payment.

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

What if my practice isn't eligible for the PNIP but is financially disadvantaged?

Grandparenting payments are available for the first three years of the PNIP to make sure non-accredited practices not eligible for PNIP, aren't financially disadvantaged by the removal of the six removed MBS practice nurse items and any associated BBI items. Grandparenting payments will be paid until 31 December 2014. Applications for grandparenting payments closed on 30 June 2012.

Practices that are not eligible for the PNIP may receive quarterly grandparenting payments, up to the amount they would have earned from the removed six MBS practice nurse items and any associated BBI items. Grandparenting payments are based on MBS billing history from the relevant quarter in the historical period.

To continue receiving the maximum 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. These hours must be maintained in order for the practice to receive the maximum grandparenting payment.

If a practice receiving a grandparenting payment registers for accreditation, they may then be eligible to join the PNIP. Human Services will assess the practice to determine if it is still financially disadvantaged and eligible for a top-up payment instead of a grandparenting payment.

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

DVA loading

Practices that are eligible for the PNIP and provide GP services to DVA Gold Card holders are eligible for an annual payment for each veteran. These practices will be identified by Human Services and payments will be made in the August quarter.

A GP must provide consent for their MBS billing data for services provided to DVA Gold Card holders to be included in the calculation of the practice's annual DVA loading. If the GP does not provide consent to use their MBS billing data, those DVA services can't be included in the calculation of the DVA loading.

The DVA loading is calculated by determining the number of Gold Card holders who receive an 'in room' consultation in an eligible practice each year. An amount is paid for each DVA Gold Card holder, regardless of the practice location, nursing qualifications or the number of nurses in the practice. There is no limit on the number of DVA loadings paid per practice.

When a DVA Gold Card holder goes to more than one practice each year, the DVA loading is shared across the practices based on the percentage of total consultation fees paid.

Example

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

Practice	**Serviceitems**	**% Total annual cost**	**% Total DVA component**
A	2 x Item 23	29%	29%
B	3 x Item 23 and1 x Item 36	57%	57%
C	1 x Item 23	14%	14%

Accreditation assistance

To be eligible for the one-off $5000 accreditation assistance payment, a practice must be registered for accreditation against the *RACGP Standards for general practices*. Practice branches are not eligible for the payment.

The practice must join the PNIP, provide Human Services with proof of registration for accreditation and become accredited within 12 months of joining the PNIP.

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

When payments are made

Payments are calculated and paid retrospectively on a quarterly basis. To qualify for payments, practices must have lodged their completed application for the PNIP by the point-in-time date. The point-in-time date is the last day of the month before the next PNIP quarterly payment.

Quarterly payment month	**Point-in-time assessment of eligibility**	**Reference period**
February	31 January	1 November to 31 January

Quarterly payment month	Point-in-time assessment of eligibility	Reference period
May	30 April	1 February to 30 April
August	31 July	1 May to31 July
November	31 October	1 August to 31 October

The quarterly payment is made when a practice meets the eligibility requirements for a payment in the reference period. For example, the May quarterly payment for the PNIP is made for having met the eligibility requirements for all, or part of, February, March and April.

The DVA loading is paid in the August quarterly payment each year. The payment advice will identify each eligible veteran for whom a payment is made.

How payments are made

PNIP payments are made electronically to the account nominated by the practice. PNIP payments do not attract Goods and Services Tax.

Withheld payments

Payments to practices may be withheld by Human Services for a number of reasons including:

- 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 isn't supervised by a registered nurse
- a change of practice ownership
- non-compliance
- expiry of accreditation
- significant changes in practice data
- the practice or practitioners do not have the required insurances, and/or
- incomplete or inaccurate practice details.

Practices need to confirm practice details before calculation of the quarterly payment. If practices do not confirm details in the QCS, PNIP payments will be withheld. Human Services will let practices know why payments have been withheld and what information needs to be provided in order for payments to be released.

Once the information is provided and the practice is assessed as eligible for payments, Human Services 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 QCS process) and payments are withheld by Human Services for three consecutive points-in-time, the practice's entitlement will be stopped under the

PNIP. In addition, practices that have their quarterly payment calculated to be $0 at three consecutive points-in-time will have their entitlement stopped under the PNIP.

If a practice's entitlement has been stopped 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. If a practice reapplies 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 resolved after a practice has had their entitlements stopped or withdrawn from the program, the practice will need to complete a new application form to rejoin the PNIP. Practices rejoining the PNIP will need to be fully accredited to receive PNIP payments. Practices are now unable to reapply for grandparenting or top-up arrangements as applications for financial disadvantage closed on 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 get accreditation, and are not eligible for any further payments beyond this period. Once accreditation is achieved, payments will start from the date of accreditation. The practice will be removed 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. 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 removed 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 the table below.

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

1st point-in-time	**2nd point-in-time**	**3rd point-in-time**	**Practice's entitlement to PNIP stops**
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

If PNIP payments have been made as a result of an administrative error or inappropriate claiming, Human Services can seek to recover these payments.

Payment advices

Practices will receive a payment advice after each payment outlining practice and payment details. Practices should check their PNIP payment advice is correct.

Practices that make false or misleading claims or fail to notify Human Services of any changes which affect their entitlement to PNIP payments may have to pay back any payments received incorrectly.

Maintaining and changing practice information

Notification of changes

It is important that practices let Human Services know of any changes in practice arrangements that may affect their eligibility for the PNIP. Practices have 14 calendar days to advise of changes, and need to make sure this information is provided by the point in time date. This will make sure the changes are taken into account to calculate the practice's next quarterly PNIP payment. When inaccurate information is used, the practice may not receive all of its entitled payments and any overpayments may need to be recovered by Human Services. Relevant changes include:

- changes in accreditation 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 for PNIP payments
- changes to the authorised contact person(s)
- 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
- 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.

An *Individual General Practitioner details and declaration form* will need to be submitted for each new GP that joins the practice.

Practices can make changes to the practice arrangements using PNIP Online. Practices that can't access PNIP Online must advise all changes in writing, using the appropriate form available at **humanservices.gov.au/healthprofessionals** signed by the authorised contact person, and, where necessary, witnessed by another person registered with the practice. Changes to practice details should be sent to:

Mail: Practice Nurse Incentive Program
Department of Human Services
GPO BOX 2572
ADELAIDE SA 5001

Fax: 1300 587 696*

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

Quarterly Confirmation Statements

Human Services provides a Quarterly Confirmation Statement (QCS) to all practices receiving incentive payments, top-up payments and grandparenting payments each quarter before payment.

Practices need to confirm their details in the QCS before the payment can be released.

Practices will receive their QCS through PNIP Online. If you don't have access to PNIP Online, Human Services will mail the confirmation statement.

If a practice doesn't complete the QCS by the point-in-time for eligibility assessment, the practice's payment will be withheld until the next quarterly payment.

Transferring the SWPE value of a practice

In general, the SWPE value of a practice remains with the location. For example, if a practice is sold and the original owners relocate, the SWPE value will remain at the original location. The relocating practice is required to apply to participate in the PNIP and will need to establish a historical SWPE value. While the SWPE value is being established, the start-up SWPE value of 1000 will apply (see **Practices without an historical SWPE**). It is the practice owner's responsibility to ensure that the SWPE value of the practice is taken into account in the sale price.

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

Practice amalgamations

For the purposes of the PNIP, DoHA 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 after the amalgamation.

The term 'local area' refers to the same suburb, same street, same postcode, around the corner etc. There is no specific kilometre limit as this does not take into account differences between urban and rural settings. Whether a practice has moved within a local area is determined by Human Services.

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 the above requirements, the practice will need to apply for the PNIP as a new practice and establish a historical SWPE value (see **Practices without an historical SWPE**). 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.

Relocation

The SWPE value of a practice may be transferred when a practice relocates if:

- 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 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 make sure 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 need to provide evidence of this to Human Services 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, payments will be withheld. Withheld payments will only be released for the period that evidence of accreditation is provided. 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 needs to register for accreditation and provide evidence of this to Human Services by the point-in-time eligibility assessment date following the sale. If the new practice owners have not registered the practice for accreditation, 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 Human Services to remain eligible for PNIP payments. Practices that do not provide Human Services with evidence of an extension will have their payments withheld.

Reinstatement

Practices that withdraw from the PNIP or are no longer entitled to payments due to ineligibility or non-compliance will need to reapply for the PNIP (excluding grandparenting). These practices will be assessed as a new applicant and will need to be fully accredited to be eligible to participate.

Grace periods

If a practice nurse, Aboriginal Health Worker or allied health professional leaves a practice receiving funding from the PNIP, the practice has 21 days to replace them before it affects the calculation of incentives.

If a practice nurse, Aboriginal Health Worker or allied health professional leaves a practice that is receiving funding from the PNIP, the practice has 45 calendar days to replace them before it affects the calculation of incentives, if the practice is:

- receiving a rural loading based on the ASGC-RA classification
- an Aboriginal Medical Service or Aboriginal Community Controlled Health Service, or

- in area of urban workforce shortage.

If a practice can't replace the practice nurse, Aboriginal Health Worker or allied health professional within 45 calendar days, the practice has 14 calendar days to notify Human Services of the change in their circumstances.

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

What are the obligations of the practice?

The practice must:

- be able to prove its claims for payments, including any documentary evidence
- provide information to Human Services as part of its audit program to make sure the practice meets the PNIP eligibility requirements
- make sure information provided to Human Services is accurate, and
- advise Human Services through PNIP Online or in writing of any changes to practice arrangements by the relevant point-in-time or within 14 calendar days, whichever is earliest.

The practice must nominate an authorised contact person(s) who will need to confirm, on the practice's behalf, any changes to information 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 Human Services within 28 days of receiving the decision they want reviewed.

The request must include the following details:

- the name and address of the person requesting the review
- the name and identification number of the practice
- the decision to be reviewed, and
- the grounds for requesting the review including any supporting documentation.

Human Services will review its decision in accordance with the PNIP eligibility criteria and/or payment formula and advise the practice in writing of the outcome.

If a practice isn't satisfied with the review decision, the practice can ask for the decision to be considered by a Formal Review Committee. More information on the formal review process is available by calling **1800 222 032*** 8.30 am–5.00 pm, Monday to Friday, Australian Central Standard Time.

Human Services may withhold a practice's quarterly payment if a review of decision has been requested. Human Services will make this decision on a case by case basis.

For more information

Online: **humanservices.gov.au/pnip** then Incentives and Allowances > Practice Nurse Incentive Program

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

Call: **1800 222 032***8.30 am–5.00 pm, Monday to Friday,Australian Central Standard Time.

* Call charges applies for mobile and pay phones only

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. It is the responsibility of the practice to ensure they are referencing current guidelines.

The Commonwealth doesn't 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.

Attachment A—Examples of payment calculations—July 2012

The following table shows the incentive amounts based on SWPE values. Payments are based on a practice's actual SWPE values and the incentive is adjusted accordingly.

SWPE	**Minimum number of practice nurse hours per week for full incentive payment**	**Incentive for a registered nurse or allied health professional**	**Incentive for an enrolled nurse or Aboriginal Health Worker**
1000	12 hours 40 minutes	$25 000	$12 500
2000	25 hours 20 minutes	$50 000	$25 000
3000	38 hours	$75 000	$37 500
4000	50 hours 40 minutes	$100 000	$50 000
5000	63 hours 20 minutes	$125 000	$62 500

The following scenarios are examples only and have been calculated using the ready reckoner available at **humanservices/healthprofessionals** then **Allowances and Incentives > Practice Nurse Incentive Program.**

Scenario 1

The Redtown Family Practice is an accredited general practice with a SWPE value of 3000. 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 year or $18 750 per quarter.

Scenario 2

The Bluetown General Practice has a SWPE value of 3000 and employs a RN for 19 hours per week and an Enrolled Nurse (EN) for 19 hours per week.

The Bluetown General Practice is eligible for an RN incentive of ($37 500) and an EN incentive of ($18 750) totalling $56 250 per year 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 5000. 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 5000, it is only eligible for an incentive based on one full-time practice nurse. The incentive would be equivalent to $75 000 per year 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 per cent loading is applied to this practice's incentive as it is in a RA3 location. Greentown General Practice has a SWPE value of 2000 and two RNs who job share, working 25 hours 20 minutes per week between them.

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

Scenario 5

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

The Aboriginal Medical Service has a SWPE value of 2000 and three Aboriginal Health Workers who each work 38 hours per week. The Aboriginal Medical Service SWPE value would be increased by 50 per cent to 3000.

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

Scenario 6

The Greytown General Practice employs 15 GPs working various hours, has a SWPE value of 7250 and employs three practice nurses for 55 hours per week (two RNs working 20 hours per week and one EN working 15 hours per week).

The SWPE value for the Greytown General Practice is capped at 5000 and the practice is eligible for a payment totalling $93 750 per year or $23 438 per quarter.

Scenario 7

The Pinktown General Practice employs seven GPs working various hours, has a SWPE value of 5456 and employs two RNs for a total of 69 hours per week.

The SWPE value for the Pinktown General Practice is capped at 5000 and the practice is eligible for the maximum payment of $125 000 per year 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 before the PNIP was introduced, it had 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 associated BBI 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 4000. Based on this information, the Whitetown General Practice is eligible for an incentive of $100 000 per year or $25 000 per quarter under the PNIP.

With the GPs' consent, the Whitetown General Practice provided Human Services with details of the GPs at the practice during the historical period. Human Services used this information to assess if the practice was financially disadvantaged by the introduction of the PNIP.

Where the value of the MBS practice nurse items, BBI 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 PNIP.

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.

	Quarter 11 Nov–31 Jan	**Quarter 21 Feb–30 Apr**	**Quarter 31 May–31 Jul**	**Quarter 41 Aug–31 Oct**	**Annual Total**
Historical period quarters	1 Nov 2010 – 31 Jan 2011	1 Feb 2011 – 30 Apr 2011	1 May 2011 – 31 Jul 2011	1 Aug 2010 – 31 Oct 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	RN – 50 hrs 40	RN – 50 hrs 40	RN – 50 hrs 40	RN – 50 hrs 40	

	Quarter 11 Nov–31 Jan	Quarter 21 Feb–30 Apr	Quarter 31 May–31 Jul	Quarter 41 Aug–31 Oct	Annual Total
hrs/week—historical period	min	min	min	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 hour 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	$7000	$8000	$2000	$17 000
Total payment (C+B)	$25 000	$32 000	$33 000	$27 000	$117 000

[#] Includes any associated BBI items.

Scenario 9

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

The Whitetown General Practice is accredited and before the PNIP was introduced it had 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, associated BBI 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 changes, as detailed in the table below. The Whitetown General Practice has a SWPE value of 4000.

With the GPs' consent, the Whitetown General Practice provided Human Services with details of the GPs at the practice during the historical period. Human Services used this information to assess if the practice was financially disadvantaged by the introduction of the PNIP. Where the value of the MBS practice nurse items, associated BBI 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. These arrangements will continue for the first three years of the PNIP.

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

	Quarter 11 Nov–31 Jan	**Quarter 2 1 Feb–30 Apr**	**Quarter 31 May–31 Jul**	**Quarter 4 1 Aug–31 Oct**	**Annual total**
Historical period quarters	1 Nov 2010 – 31 Jan 2011	1 Feb 2011 – 30 Apr 2011	1 May 2011 – 31 Jul 2011	1 Aug 2010 – 31 Oct 2010	
Combined MBS practice nurse items [#] and PIP Practice Nurse Incentive—historical period	$25 000	$32 000	$33 000	$27 000	$117 000
Contracted practice nursehrs/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 nursehrs/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 hour changes (A)	$20 000(-20%)	$25 600(-20%)	$33 000(no adjustment)	$27 000(no adjustment)	$105 600

	Quarter 11 Nov–31 Jan	Quarter 2 1 Feb–30 Apr	Quarter 31 May–31 Jul	Quarter 4 1 Aug–31 Oct	Annual total
PNIP Incentive Payment (B)	$20 000	$20 000	$25 000	$25 000	$90 000
Top up amount (C = A-B)	$0	$5600	$8000	$2000	$15 600
Total payment (C+B)	$20 000	$25 600	$33 000	$27 000	$105 600

[#] Includes any associated BBI items.

Scenario 10

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

The Orangetown General Practice is a non-accredited practice and before PNIP was introduced it used 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 and associated BBI 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 provided Human Services with details of the GPs at the practice during the historical period. Human Services used this information to assess if the practice was financially disadvantaged by the introduction of the PNIP. The Orangetown General Practice is 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.

	Quarter 11 Nov–31 Jan	Quarter 21 Feb–30 Apr	Quarter 31 May–31 Jul	Quarter 41 Aug–31 Oct	Annual Total
Historical period quarters	1 Nov 2010 – 31 Jan 2011	1 Feb 2011 – 30 Apr 2011	1 May 2011 – 31 Jul 2011	1 Aug 2010 – 31 Oct 2010	
MBS Practice Nurse items[#]— historical period	$25 000	$32 000	$33 000	$27 000	$117 000

	Quarter 11 Nov–31 Jan	Quarter 21 Feb–30 Apr	Quarter 31 May–31 Jul	Quarter 41 Aug–31 Oct	Annual Total
Contracted practice nursehrs/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 nursehrs/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 hour 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

[#] Includes any associated BBI items.

Scenario 11

Example of grandparenting payment where the same 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 before PNIP was introduced it used 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 and associated BBI 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 changes and are detailed in the table below.

With the GPs' consent, the practice provided Human Services with details of the GPs at the practice during the historical period. Human Services used this information to assess if the practice was financially disadvantaged by the introduction of the PNIP. The Orangetown General Practice is 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.

	Quarter 11 Nov–31 Jan	Quarter 21 Feb–30 Apr	Quarter 31 May–31 Jul	Quarter 41 Aug–31 Oct	Annual Total
Historical period quarters	1 Nov 2010 – 31 Jan 2011	1 Feb 2011 – 30 April 2011	1 May 2011 – 31 Jul 2011	1 Aug 2010 – 31 Oct 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

[#] Includes any associated BBI items.

Attachment B—Role for nurses in general practice settings—July 2012

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

Nurses employed in general practice can include registered nurses, enrolled nurses, nurse practitioners and midwives. Aboriginal Health Workers and allied health professionals can also be employed in general

practice. These health professionals provide services together with medical practitioners working in a practice.

Participating midwives and nurse practitioners (see definitions below) are non-referred health professionals. While they may work and be employed in a general practice, they provide Medicare services in their own right and can't participate in the Practice Nurse Incentive Program (PNIP).[1]

The role of nurses in general practice may vary between 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 (for example, types of services delivered and outreach), and
- practice management, culture, values and attitude.

Nurses in general practice work to professional standards based on the general professional competency standards for the registered and enrolled nurse which have been defined for the general practice setting. These standards are available at **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.[2]
- 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.[2]
- Participating midwife—an eligible midwife who provides Medicare services in a collaborative arrangement with one or more medical practitioners as specified in the regulations.[3]
- Participating nurse practitioner—an eligible nurse practitioner who has a minimum of a Masters level of qualification and provides Medicare services collaborative arrangement with one or more medical practitioner/s as specified in the regulations.[3]

Supervision of the enrolled nurse

The EN is legally required to be supervised by a RN and is accountable and responsible for all aspects of delegated care.[4] ENs provide care as part of the healthcare team under the supervision and direction of the RN.[5] RNs may supervise and direct ENs directly or indirectly.

Direct supervision is when the RN is present, 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 doesn't directly observe the activities of the EN. This needs processes to be in place for the direction, guidance, support and monitoring of the EN's activities. The RN needs to observe and assess the EN's competence before entering into an indirect supervisory arrangement. The RN can be located off-site, but must be available for regular direct communication through a structured arrangement.

The role of nurses in general practice

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.[5]

The role of nurses varies across general practice, and may include, but isn't 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
- participating in professional development to remain competent and aware of current best practice
- educating other members of the general practice team 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, or
    - 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 people[6 7]
- reactive and strategic problem solving and improving systems or processes in the practice, and
- clinical systems management—updating practice and clinical policies and procedures and developing/maintaining clinical reports.

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 an RN.

Provision of clinical nursing services through:

- triage
- emergency management
- holistic health assessment including patient history, health screening and physical and preventative health checks—for example, 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 and review of GP Management Plans and Team Care Arrangements
- 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, and
- diagnostic services including ECGs, stress tests, urine drug screening, hearing tests, peak flow, spirometry and mood and 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 assistance, and
- educating patients in areas including:
    - 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 (for example, Influenza)
    - domestic violence, quit smoking, drug and alcohol guidance, advice and/or support
    - support for weight reduction through provision of exercise and dietary information, and
    - maternal and child health including antenatal care and well baby checks.

Improving health outcomes through:

- outreach services, for example, 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, and
- nurse led clinics—RNs with advanced skills may also conduct nurse led clinics, for example, maternal and child health, education and monitoring of various conditions.

Management of clinical care systems

Nurses in general practice can develop, coordinate and administer systems and processes which help the general practice to anticipate and manage health care interventions, mediate risk and facilitate quality care outcomes.[5] This can include:

- maintaining, monitoring and improving patient information systems including the patient register and recall systems
- practice population profiling—collecting and analysing information, including Indigenous population levels, 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
- maintaining cold chain for vaccines
- stock control including medicines and compliance with various legislation, and
- cleaning and sterilisation of instruments in accordance with industry standards, minimising risk of healthcare 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 use of practice nurses to undertake a broader range of tasks
- practice base—provision of multi-disciplinary team based care, and
- practice capacity to adapt to change—effective use of the multi-disciplinary team to better support older patients, those with chronic disease and address patient expectations.

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.[5] This can include:

- 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 for the smooth transfer of client care between health care sectors—including 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, and
- patient advocacy.

For more information

Australian Practice Nurse Association (APNA)**apna.asn.au**

Australian General Practice Network (AGPN)—nursing in general practice**generalpracticenursing.com.au**

Australian Nursing Federation—Fact sheet: A snapshot of practice nurses in Australia**anf.org.au > Fact Sheets >FactSheet No. 7: SnapShot of general practice nurses in Australia**

Australian Nursing Federation—competency standards **anf.org.au> Competency standards**

Department of Health and Ageing—nursing in general practice—education and training **health.gov.au> For health professionals > Health workforce > Nurses > Nursing in general practice program**

Royal College of Nursing Australia (RCNA)—*Nursing in General Practice—a guide for the general practice team***rcna.org.au> Media and publications > Publications >Nursing in general practice**

1 From 1 November 2010 eligible midwives and nurse practitioners have access to Medicare arrangements which include providing Medicare 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.

2 Adapted from Royal College of Nursing Australia. 2005. Nursing in General Practice. A Guide for the General Practice Team. Available at rcna.org.au

3 Health Insurance Act 1973.

4 Australian Nursing Federation, 2005. Competency Standards for nurses in general practice. ANF, Canberra. Available at anf.org.au

5 Australian Nursing and Midwifery Council (ANMC) 2002. National Competency Standards for the Enrolled Nurse. ANMC, Canberra. Available at capdivgp.com

6 AHMAC Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009, Australian Health Ministers' Advisory Council. Available at health.gov.au

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

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