Australian Primary Health Care Nurses Association

Redesigning the Practice Incentives Program

APNA SUBMISSION

Australian Primary Health Care Nurses Association (APNA) is the peak professional body for nurses working in primary health care. APNA champions the role of primary health care nurses; to advance professional recognition, ensure workforce sustainability, nurture leadership in health, and optimise the role of nurses in patient-centred care.

APNA is bold, vibrant and future-focused. We reflect the views of our membership and the broader profession by bringing together nurses from across Australia to represent, advocate, promote and celebrate the achievements of nurses in primary health care.

SUMMARY OF KEY POINTS

1. APNA supports the redesign of the Practice Incentives Program (PIP).
2. APNA recommends team-based and nurse-led care be incorporated into the PIP redesign.
3. The role of nurses working in primary health care may suffer adverse unintended consequences as a result of the redesign of the PIP, and care should be taken to minimise this.
4. The PIP redesign creates an opportunity to record and track nurse activity in general practice.
5. APNA can see the benefit of combining PIP incentives to potentially reduce the administrative burden associated with the claiming process. However, if the administrative burden of the new system remains onerous, it may have a negative impact on general practices' engagement in quality improvement, nursing employment and time spent on administration.
6. APNA recommends expansion of the PIP Teaching Payment to include nurses.
7. APNA recommends already high performing practices, or those with hard to reach populations, should not be penalised by the redesigned system and should be able to access the PIP.

INTRODUCTION

"Good primary care is vital for good health. But Australian primary care is failing in one crucial area: the prevention and management of chronic disease."[1] APNA supports the potential opportunity that the redesign of the Practice Incentives Program (PIP) offers. Practices will be enabled to expand their scope of quality improvement beyond the currently PIP-funded conditions.

Australia's health system was designed for acute and episodic illness in an era when those were the commonest presentations. Today we are primarily treating chronic and long term disease. Demands on the health system are growing at a level which is economically unsustainable. As many as one in five Australians live with two or more chronic health conditions, and half of all potentially avoidable hospital admissions in 2013–14 were attributed to chronic conditions.[2]

APNA's members see the enormity of this challenge daily. Primary health care nurses are acutely aware of how Australia's chronic disease epidemic reduces quality of life for patients, with flow-on effects for their families, carers and household income. They know how it strains our health system.

In 2016 the Australian Government stated it, "would work towards changing the PIP through the measure entitled *Quality Improvement in General Practice – Simplification of the PIP*. The redesign of the PIP will introduce a new Quality Improvement Incentive which will give general practices increased flexibility to improve their detection and management of a range of chronic conditions, and to focus on issues specific to their practice population."[3]

NURSE-LED CARE

Nurses currently play an integral role in the activity that contributes to PIP, and should be incorporated into the PIP redesign.

Nurses are the largest group of health professionals in Australia and play a pivotal role in health service delivery at every stage of a patient's journey.[4] Primary health care nurses working within a general practice setting often perform the following roles: patient carer, organiser, quality controller, problem solver, educator, and agent of connectivity.[5] Nurse-led services commonly provided in primary health care are health assessments to monitor a patient's health condition and symptoms, health education to facilitate compliance and a healthy lifestyle, and coordination of care.[6] Therefore, nurses currently play an integral role in the activity surrounding PIP and should be incorporated into the PIP redesign.

APNA sees opportunities in the redesign of the PIP to utilise the existing nursing workforce, particularly in the role of nurse-led services. Studies overwhelmingly show that nurse-led clinics and services result in improved health outcomes, shorter waiting times for patients and decreased rates of hospital admission. For areas of health workforce shortages and rural and remote areas with limited access to health care services, nurse-led clinics can offer patients vital access to health advice and treatment.[7] Not only are nurses suited to a lead role, research has also shown that expanding the role of the nurse to lead services can prevent costly hospitalisation while providing safe, efficient and high quality care.[8]

DATA COLLECTION AND SHARING

- **Nurses should be empowered within the PIP redesign to consolidate their already existing role of quality controller and improvement agent.**
- **Under the PIP redesign, the nurse contributions to service delivery and care should be visible within the data set. As per accreditation standards nurses should have an individual login to clinical software packages which should enable a data extraction tool to collect and track nurse activity.**

Nurse role as quality controller and improvement agent

Currently primary care nurses are key drivers of improvement and change in general practice settings. Primary care nurses are pivotal in collecting patient data, using data to drive responses to the practice population and improve health, and submitting data for funding requirements. This includes data entry, cleaning and extraction.

The Australian Nursing and Midwifery Federation's *National practice standards for nurses in general practice* states nurses need to, "Demonstrate proficiency in a range of data gathering techniques and nursing assessment skills within the RN scope of practice."[9] These skills are required in any system change, such as the PIP redesign, where organisations are constantly appraising their data to meet quality benchmarks. Nurses should be empowered within the PIP redesign to consolidate their already existing role of quality controller and improvement agent.

Lack of nursing data

Current administrative and data requirements for general practices means there is little data currently available on the nature of the clinical work and activities carried out by nurses working in general practice. This includes: conditions treated, services provided, and the type of patients seen by nurses.[10] Therefore the contribution of nurses in general practice is largely unsubstantiated.

There are three main issues pertaining to the lack of data available to nurses working in general practice:

1. Not all practices enable nurse data to be searchable (e.g. they don't have their own nurse appointment schedule and/or login, or they don't set up nurse-specific codes for nurse appointments in their system).
2. The data which has been historically looked at (e.g. the BEACH study) has concentrated only on general practitioner data.
3. General practices generally operate as small businesses in 'silos' and therefore have not had a mechanism or a driver to share data.

The PIP redesign is an opportunity to track nurse-related activity. Any data system developed for the PIP redesign resulting in an upload to the data custodian should require every individual in the health care team, including nurses, to have their own account and coding. This will enable tracking of nurse activity so that nurse contribution to the PIP can be clear, searchable, quantified and analysed. If nursing activity is not searchable and quantifiable, the value of nurses to improving population health needs is invisible.

Being unable to justify nurses' financial contribution to the practice with data also impacts the perceived value of nurses, and therefore their employment security and opportunity in general practice.

ENSURING NURSES' SCOPE OF PRACTICE IS NOT ADVERSLY AFFECTED

- The lessons learnt from the introduction of the Practice Nurse Incentive Program (PNIP) should be taken into account when redesigning the PIP.
- Caution should be taken to minimise adverse effects the redesign of the PIP may have on the role of nurses working in primary health care.

System constraints impact on the activity of nurses working in general practice. Whilst APNA supports the concept of the Practice Nurse Incentive Program (PNIP), the good intention of the program to improve health services targeted to local populations, encourage practices to undertake broader nursing services and to maximise nurses' scope of practice has been warped by some employers and managers.

The removal of specific financial incentives was noticeable in a small business model – particularly as the income was redistributed from the general practitioner to the practice – and some drew a correlation between the loss of MBS income and the worth of nurse employees, despite the block payment available to practices.

The adverse effect of the program is illustrated in the following statements:

> *"When nurse items numbers were in place, I felt the service I was providing was acknowledged in a dollar value and this then could be used a bargaining chip when trying to negotiate a wage review. With the nurse items numbers being withdrawn, that bargaining chip is gone. My hours have actually been reduced, despite having the same workload."*
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> *"Since item numbers have been removed, it doesn't allow for the nurses to work independently within the clinic and charge only their item number, and in order for them to maintain their position the doctor is always involved in the consultation."*

As small businesses the financial contribution of a nurse is an important factor in the decision to employ a nurse or nurses. If practice incentive payments are consolidated as proposed, the nurse's financial contribution to the practice is less visible and demonstrable and the risk is that the role and scope of nurses working in general practice will be further reduced.

APNA urges the Department to consider any adverse effects the redesign of the PIP may have on the role, scope of practice, and employment of nurses working in primary health care.

ADMINISTRATIVE BURDEN

- Combining PIP payments may reduce the administrative burden on nurses.
- If the administrative burden is equally or more onerous under a redesigned system it will have a negative impact on payments, nurse employment and time spent on administration.

A recent study found that, "administrative support available to GPs appears to be an increasingly important predictor of incentive use, suggesting that the administrative burden of claiming incentives is large and not always worth the effort."[11] Current PIP payments have an administrative burden and each PIP has different administration. This requires nurses and other practice staff to have a:

- sound understanding of different PIPs,
- plan for implementing and monitoring PIP payments, and
- robust reminder system to ensure care is delivered at intervals which will ensure payments are received (i.e. if a patient comes in too early the practice is not eligible for payment even if care has been provided).

Combining PIP payments may reduce the administration burden on nurses, and reduce the need for nurses and other staff to invest time staying on top of the administrative needs of multiple types of PIP. It is important to consider administrative costs and burden when redesigning the PIP, especially for nurses who are often the drivers of quality improvement and responsible for data management. Depending on the data required to receive a Quality Improvement Payment, if the administration burden is onerous, it will have a negative impact on payments, nursing employment and time spent on administration.

COMMUNICATION OF THE REDESIGN

- **It is crucial the Department communicates the redesign effectively to minimise pessimism around a new incentive structure.**
- **APNA can assist the Department with the change management campaign, leading primary health care nurse engagement.**

It is crucial the Department communicates the redesign effectively in order to get buy-in from general practices for the redesign. APNA can lead engagement and education of a new model to general practice nurse audiences.

APNA is ideally placed and experienced in disseminating information to primary health care nurses with digital, print and face to face opportunities.

TEACHING PAYMENT

APNA recommends expansion of the Teaching Payment to include nursing.

There is projected to be a substantial shortage of nurses in Australia, and this shortage will be felt most acutely in the primary health care sector. Health Workforce Australia's 2014 report *Australia's Future Health Workforce* contains workforce planning projections showing a projected shortfall of approximately 85,000 nurses in Australia by 2025, and 123,000 nurses by 2030 under current settings.[12]

The redesign of the Practice Incentives Program needs to support capacity building among the primary health care nursing workforce by promoting the employment of, and providing support to, nurses working in primary health care settings. This includes improving employment opportunities, recruitment and retention of nurses in primary health care settings, and ensuring that nurses working in primary health care settings have the knowledge and skills to deliver best practice clinical services in priority areas of primary health care.

One strategy to address the nursing workforce shortage is to expand the PIP Teaching Payment. Currently the PIP Teaching Payment only allows for payment to medical practitioners. There should be consideration for

practices being paid for teaching nurses. This could be a payment for experienced nurses to teach graduate nurses, nurses transitioning into primary health care, or nurses working towards a higher qualification.

IMPROVEMENT PAYMENT ONLY BEING MADE IF THERE IS IMPROVEMENT IN SPECIFIC AREAS

APNA recommends that already high performing practices should not be penalised by the redesigned system, and ensure the system accommodates those who are achieving a high level of quality improvement now.

Currently practices can claim PIPs for the provision of high quality care. Model three of the PIP redesign is that a quality improvement incentive payment is available *only* if improvement is demonstrated through data. This may be problematic if practices are already providing high quality care, and as such have a limited capacity to improve their data and model of care and therefore be eligible for PIP income. Another issue is if clinics have a hard to reach population they might not be able to meet predetermined benchmarks.

APNA recommends the redesigned system accommodates already high performing practices, or those with hard to reach populations, so they can still seek to achieve quality improvement under the Practice Incentives Program.

CONCLUSION

APNA is optimistic about a redesigned Practice Incentives Program as a way of fostering quality improvement and driving innovation in general practice. We see our nurse members – highly trained, cost effective and trusted – as stepping up to make a significant contribution to innovation in primary health care. APNA calls for policy-makers to ensure the new PIP system pursues truly team-based, multidisciplinary care which puts patients at its heart.

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