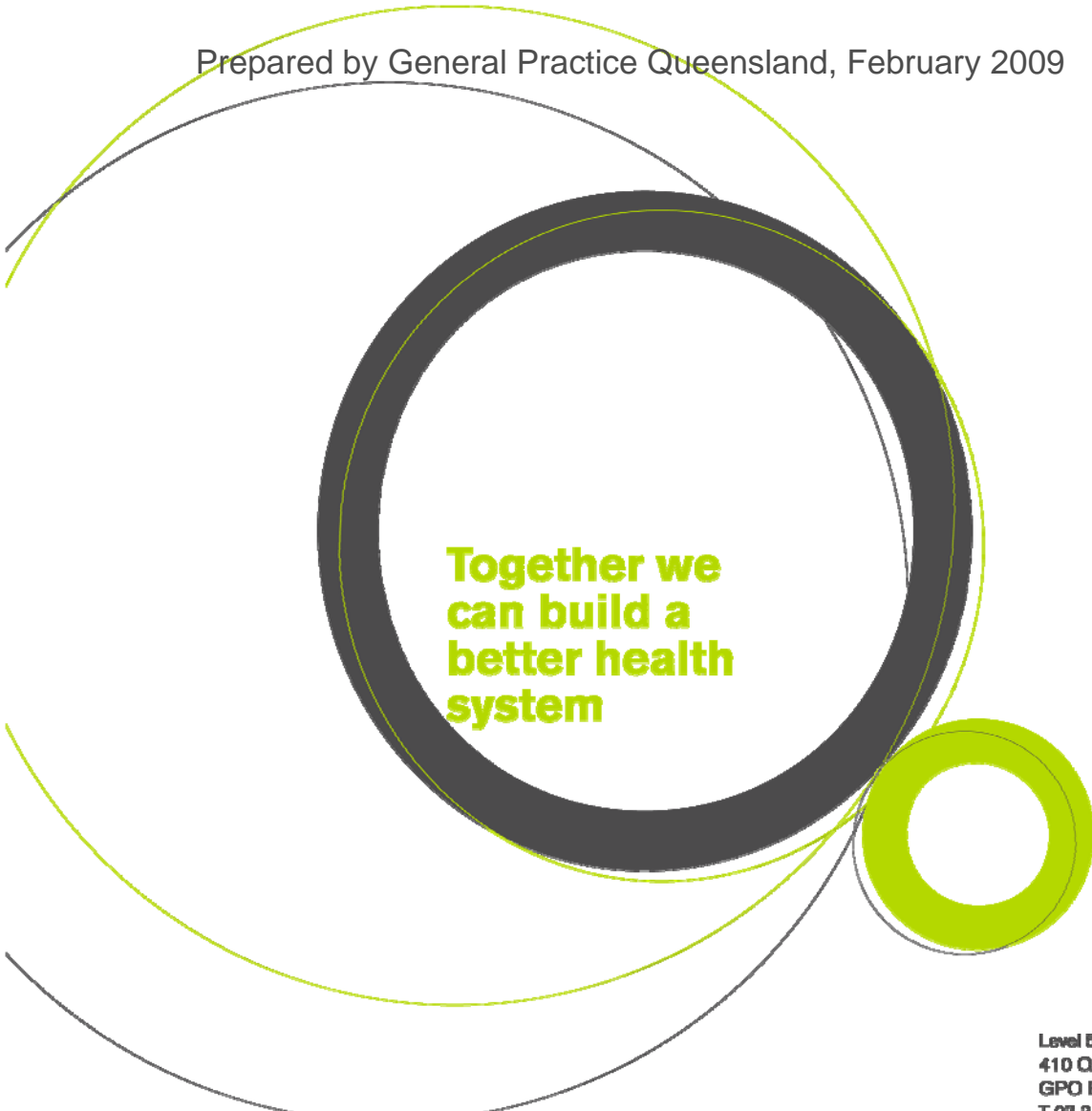


Mental Health Nurse Incentive Program

Feasibility Study

Prepared by General Practice Queensland, February 2009



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can build a
better health
system**

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1.0 Executive Summary

The *Mental Health Nurse Incentive Program* was launched in July 2008 as part of the CoAG National Action Plan on Mental Health 2006-2011. The Program provides a non-MBS incentive payment to eligible organisations to engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental illness.

This document explores the feasibility of the Program, and aims to provide information and guidance to eligible organisations who are considering adopting the Program. The document includes an overview of the current mental health landscape, as well as a copy of the most up-to-date 'program details', which give a good outline of the rules, restrictions and guidelines that need to be considered before undertaking the Program.

Examples of various models of service delivery are discussed, compared and contrasted, and a SWOT analysis has been undertaken from the perspectives of the key stakeholders who are likely to be involved. Examples of financial models being implemented are also included, along with commentary on the real-world implications of these figures.

The final section is dedicated to addressing some of the most commonly asked questions around credentialing, training, rates of pay and the future of the Program.

Given the intention of the authors to remain unbiased about the Mental Health Nurse Incentive Program, we have refrained from including recommendations about whether an organisation should adopt the Program. We hope this document provides enough information, or pathways onto further information, to allow each organisation to make an informed decision.

2.0 Background Information/Needs Assessment

In determining the feasibility of any new program, including the Mental Health Nurse Incentive Program, it is important to understand the landscape within which the new program will sit. This will assist in identifying the existing strengths and limitations of the environment, namely the delivery of mental health services in Queensland, and will aid in determining whether the new program will deliver the solutions needed.

The first issue to consider is the help-seeking habits of people with a mental illness. In 1997, the National Survey of Mental Health and Well Being (Australian Bureau of Statistics, 1998) revealed that 62% of people with mental illness do not seek assistance for their mental health concern. Of the 38% of people who reported they did seek assistance from a health care professional, the vast majority visited their GP. Research by Mathers, Vos and Stevenson (1999) identified that over 75% of all mental health contacts occur between a patient and their GP. Further research in Queensland (Queensland Government, 2008) has suggested that of the estimated 100,000 people in Queensland experiencing serious mental illness, approximately 51% are seen by public mental health services.

These findings show a number of clear trends; most people with a mental illness do not seek help from a health care professional and of those that do, their GP is their preferred choice of provider. People with a serious mental illness are more likely to seek assistance for their disorder, with this support most often provided by State Mental Health Services, however there is still a large number of people whose mental illness is left untreated. It follows then, that any enhancements in mental health capacity within General Practice, whether it be specialist training for GPs, or the addition of mental health specialist personnel working in the primary care sector, will serve to improve the mental health of people within our community.

A second, and equally concerning issue, is the extremely poor physical health of people with a mental illness, particularly those people with a severe mental illness. The landmark study, "Duty to Care: Physical Illness in People with Mental Illness", published in 2001, identified people with mental illness as at higher risk of having a co-occurring physical illness, and of that physical illness going undiagnosed and untreated. The report indicated that death rates from all main causes amongst people with mental illness are 2.5 times higher than the general population, yet hospitalisation rates are considerably lower for many conditions. A report prepared by the Mental Health Council of Australia in 2004 (Access to Health Services by People with Mental Illness) concurred with the "Duty to Care" report, identifying a number of reasons for this inequity, including:

1. Physical illness often left undiagnosed and/or untreated, often due to the person only receiving care from a mental health professional;
2. People with mental illness are more likely to engage in high-risk behaviours such as smoking, alcohol or drug abuse, and sexual promiscuity;
3. People with mental illness are less likely to engage in health-promoting activities such as healthy diet and exercise; and
4. People with mental illness often experience stress, anger and frustration as a result of their illness, as well the stigma associated with mental illness and the side effects of medication.

By placing mental health nurses within general practice, this increases patient access to a mental health professional, who is also skilled to recognise and treat physical illnesses as well. This can only serve to minimise the effect physical illness has on a person's mental illness, and vice versa.

The third and final issue that is important to raise is the length of time required to effectively engage and support a person with a mental illness. People with a mental illness, especially a severe mental illness, usually require long consultations addressing multiple and complex issues. With hundreds, and in some

cases, thousands of patients on a GP's books, it can be frustrating for a GP to not have the time available to effectively support these patients. By having a mental health nurse located in the practice, the GP can, with confidence, refer their patient onto the nurse, and collaboratively work to support the patient, and each other. The GP's workload can effectively be reduced, by allowing a specialist mental health provider located within the practice to assist in supporting those patients with a severe mental illness.

The three issues raised above suggest that there is a place for a program that will support people with a serious mental illness being treated within the primary care setting. The *Mental Health Nurse Incentive Program* proposes to do exactly that, but as this document discusses, there are a number of factors that need to be taken into consideration when deciding whether to become involved in this Program is feasible for you (whether you are a GP, a Division of General Practice, an Aboriginal and Torres Strait Islander Primary Health Care Service, a public mental health service, or a mental health nurse yourself).

This document articulates the rules, requirements and responsibilities of the various stakeholders should you decide take on the program. An overview of the various models of service delivery is given, followed by an analysis of the strengths, weaknesses, opportunities and threats from the perspectives of the various stakeholders. Useful examples of the financial models that have been utilised are also discussed, with some commentary from people on-the-ground, as to how the model working for them. Finally, a list of a number of other issues that need to be taken into consideration before a decision can be made regarding whether you can make this Program work within your organisation, is given.

3.0 *Mental Health Nurse Incentive Program – Details*

The following information about the Mental Health Nurse Incentive Program is taken directly from the Mental Health Nurse Incentive Program – Program Guidelines developed by the Australian Government Department of Health and Ageing. This information was correct at time of printing (February 2009) however please consult the Medicare Australia website (<http://www.medicareaustralia.gov.au/provider/incentives/mental-health.jsp>) for the most up-to-date information.

3.1 Introduction

The *Mental Health Nurse Incentive Program* funds community based general practices, private psychiatric practices and other appropriate organisations to engage mental health nurses to assist in the provision of coordinated clinical care for people with severe mental health disorders.

Mental health nurses will work in collaboration with psychiatrists and general practitioners to provide services such as monitoring a patient's mental state, medication management and improving links to other health professionals and clinical service providers. These services will be provided in a range of settings, such as clinics or patients' homes and are to be provided at little or no cost to the patient.

These guidelines are primarily designed to inform eligible organisations applying for funding under this initiative.

Support provided under this initiative targets patients with severe mental health disorders during periods of significant disability. A patient should exit the Mental Health Nurse Incentive Program when he or she does not require the level of support as outlined.

3.2 Entrance criteria

General practitioners and psychiatrists will determine which patients have a severe mental health disorder and would benefit from receiving services provided under this initiative, based on the following criteria:

- the patient has a diagnosis of mental health disorder according to the criteria defined in the World Health Organisation Diagnostic and Management Guidelines for Mental Health Disorders in Primary Care: ICD 10 Chapter V Primary Care Version, or the Diagnostic and Statistical Manual of Mental Health Disorders—Fourth Edition (DSM-IV); AND
- the disorder causes significant disablement to the patient's social, personal and occupational functioning; AND
- the patient has experienced at least one episode of hospitalisation for treatment of their mental health disorder, or is at risk of requiring hospitalisation in the future if appropriate treatment and care is not provided; AND
- the patient is expected to require continuing treatment and management of their mental health disorder over the next two years; AND
- the general practitioner or psychiatrist is principally responsible for the patient's clinical mental health care; AND
- the patient provides consent to treatment from a mental health nurse.

Note: Participating private organisations and state or territory health organisations may have agreements whereby shared care health plans are in place for individual mental health patients. Under these arrangements, Mental Health Nurse Incentive Program payments are available where the organisation is the primary care provider for the mental health patient.

3.3 Exit Criteria

The patient will no longer be eligible for services under this initiative when:

- the mental health disorder no longer causes significant disablement to the patient's social, personal and occupational functioning; OR
- the patient no longer requires the clinical services of a mental health nurse; OR
- the general practitioner or psychiatrist is no longer principally responsible for the patient's clinical mental health care.

3.4 Eligible Organisations

To be eligible to participate in the Mental Health Nurse Incentive Program, organisations must be community based and have the services of a general practitioner or a psychiatrist with a Medicare Australia provider number. Eligible organisations may include:

- general practices
- private psychiatry practices
- Aboriginal and Torres Strait Islander Primary Health Care Services funded by the Australian Government through the Office for Aboriginal and Torres Strait Islander Health.

In addition, Divisions of General Practice can contract the services of mental health nurses for use by general practitioners and psychiatrists with a Medicare Australia provider number or other medical officers (as approved by the Department of Health and Ageing) working within their Division.

While state and territory health organisations are not eligible for Mental Health Nurse Incentive Program Incentive payments; they are able to make the services of their Mental Health Nurses available to participating private organisations, on a fee for service basis. These arrangements are referred to as 'shared employment arrangements', however, the nurses remain employees of the state or territory governments. The participating private organisation may claim Mental Health Nurse Incentive Program Incentive payments for sessions provided by these nurses however they cannot claim the Mental Health Nurse Incentive Program Establishment payment unless they engage other mental health nurses as employees.

See also Section 3.9 – Requirements for Eligible Organisations.

3.5 Formal Protocols for Managing Patients with Severe Mental Health Disorders

Eligible organisations must have in place a formal protocol for managing a patient's mental health care under this measure.

Where state or territory health organisations and participating private organisations have patient shared care health plans in place, the participating private organisation must:

- be the primary care giver; **AND**
- observe formal protocols described within the mental health patient shared care health plan in order to be eligible for payments under the Mental Health Nurse Incentive Program.

3.5.1 Mental Health Plan

In collaboration with the mental health nurse, a GP Mental Health Care Plan must be developed by general practitioners or an equivalent plan must be developed by psychiatrists. These plans must include specific reference to the roles and responsibilities of both the nurse and the treating medical practitioner.

Treatment must be provided according to the plan and the relevant clinical guidelines for the treatment of that disorder. A general practitioner or psychiatrist must regularly review the plan in collaboration with the mental health nurse. The review should include, where appropriate, input from a clinical psychologist, registered psychologist or other allied health professional.

The steps in preparing a GP Mental Health Care Plan are the same as those defined in Item 2710 of the Medicare Benefits Schedule (MBS) for GP Mental Health care items – see **Explanatory Notes A.32.9** and **A.32.12** of the **MBS**.

Examples of clinical practice guidelines can be found at the Royal Australian and New Zealand College of Psychiatrists website at: **www.ranzcp.org** then go to **Clinical Practice Guidelines**.

3.5.2 Health of the Nation Outcomes Scale

Mental health nurses are required to use the Health of the Nation Outcomes Scale (HoNOS) for each patient on entry to the Mental Health Nurse Incentive Program. They must subsequently measure changes to a patient's symptoms and functioning using these tools every 90 days and at the exit from the initiative. These measures include the *Child and Adolescent* (HoNOS-CA), *Adult* (HoNOS), and *Older Person* (HoNOS65+) tools.

Eligible organisations must ensure mental health nurses participating in the initiative have undergone training in undertaking HoNOS assessments (see Section 8.1 for further information).

3.6 Eligibility Requirements for Mental Health Nurses

From 31 December 2009, eligible organisations must engage the services of a mental health nurse credentialed with the Australian College of Mental Health Nurses (ACMHN).

Information on the ACMHN credentialing program can be found at: **www.acmhn.org** then go to **Credentialing**, or call **1300 667 079**.

Until 31 December 2009, interim arrangements will apply. Under these interim arrangements, eligible organisations can engage the following individuals:

- mental health nurses currently credentialed with the ACMHN; OR
- registered nurses with current registration who have obtained, or are working towards obtaining, specialist qualifications in mental health, such as a Graduate Diploma in Mental Health Nursing or a Masters in Mental Health Nursing, and three years recent experience in mental health nursing.

Eligible organisations are able to engage more than one mental health nurse.

Eligible organisations are able to enter into shared employment arrangements with state or territory health organisations for mental health nursing services. Under these arrangements, organisations are able to utilise the services of state employed mental health nurses, on a fee for service basis, and still receive *Mental Health Nurse Incentive Program* Incentive payments for sessions provided by those nurses.

See also Section 3.4 – *Eligible Organisations*.

3.7 Functions of the Mental Health Nurse

Mental health nurses engaged under this initiative will work closely with psychiatrists or general practitioners to facilitate the provision of coordinated clinical care and treatment for people with severe mental health disorders.

Services will be provided in a range of settings, such as in clinics or at a patient's home. Mental health nurse functions will include, but are not limited to:

3.7.1 Provision of Clinical Nursing Services for Patients with Severe Mental Health Disorders:

- establishing a therapeutic relationship with the patient
- liaising closely with family and carers as appropriate
- regularly reviewing the patient's mental state
- administering, monitoring and ensuring compliance by patients with their medication
- providing information on physical health care to patients.

3.7.2 Coordination of Clinical Services for Patients with Severe Mental Health Disorders:

- Maintaining links and undertaking case conferencing with general practitioners, psychiatrists, allied health workers, such as psychologists (**Note:** medical practitioners may be eligible to claim case conferencing items under MBS)
- coordinating services for the patient in relation to general practitioners, psychiatrists and allied health workers, including arranging access to interventions from other health professionals as required
- contributing to the planning and care management of the patient
- liaison with mental health personal helpers and mentors, through established links with the Mental Health *Personal Helpers and Mentors Program* as appropriate and where available.

The Mental Health Personal Helpers and Mentors Program is a complementary initiative managed by the Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), which commenced with approximately 140 full-time equivalent personal helpers and mentors in May 2007. This program facilitates access for people with severe mental health disorders to social/welfare services such as income support, employment and accommodation services.

*This program aims to create opportunities for recovery for people with a severe functional limitation resulting from a mental illness by helping them to overcome social isolation and increase their connections with the community. For further information on the Mental Health Personal Helpers and Mentors Program, visit: www.fahcsia.gov.au then go to **Individuals > Mental health***

3.8 Mental Health Nurse Caseloads

For the purpose of this initiative, a session is 3.5 hours.

Eligible organisations can engage mental health nurses from between one and ten sessions per week, per nurse, with an **average** nurse caseload of at least two individual services to patients with a severe mental health disorder per session.

As a guide, an eligible organisation engaging the services of a full-time mental health nurse must have a **current** minimum case load of 20 individual patients with a severe mental health disorder per week, averaged over three months.

When taking into account patient turnover, the expected **annual** caseload managed by a full-time mental health nurse is 35 patients with a severe mental health disorder, most of whom will require ongoing care over the course of the year.

It is expected that a full-time mental health nurse engaged for 10 sessions per week would provide an average 25 hours of clinical contact time per week, with the balance of time spent in related tasks including interagency liaison, case planning and coordination, clinical briefings to relevant general practitioners and/or psychiatrists, and travel.

Under this initiative, the typical caseload of a full-time mental health nurse will comprise of patients with different levels of care requirements that fall broadly into three groups:

3.8.1 Low Care

- patients in this group include individuals with severe mental health disorders whose clinical symptoms are well controlled but who would be at risk of relapse without ongoing clinical supervision.

3.8.2 Medium Care

- patients in this group will have active symptoms which can only be well controlled with regular clinical contact (e.g. fortnightly) and need close monitoring to prevent deterioration.

3.8.3 High Care

- patients will have persistent or fluctuating clinical symptoms, despite active treatment. They are at risk of hospitalisation or being lost to care if not actively managed. Patients in this group, on average, require frequent clinical contact.

3.9 Requirements for Eligible Organisations

To be eligible for the Mental Health Nurse Incentive Program, organisations must be able to substantiate the following when requested:

- sufficient caseload of eligible patients to engage the services of a mental health nurse for at least one session per week; **AND**
- appropriate insurance coverage, including:
 - worker's compensation in accordance with relevant state or territory legislation
 - public liability insurance of not less than \$10 million
 - professional indemnity insurance of not less than \$10 million for clinical and non-clinical work
 - vicarious liability cover of not less than \$1 million where the mental health nurse is an employee of the organisation and carrying out medical procedures or providing medical advice; **AND**
- the maintenance of appropriate and sufficient professional indemnity insurance by mental health nurses who are engaged by, but are not employees of eligible organisations – see Nursing in General Practice kit at: www.rcna.org.au then go to **Publications > Nurses in General Practice Kit; AND**
- adherence to relevant professional standards, and to the *National Practice Standards for the Mental Health Workforce 2002* at: www.aasw.asn.au then go to **Publications > Practice Standards; AND**
- the presence and use of patient reminder and recall systems; **AND**
- the appropriate qualifications and experience of mental health nurses engaged (see also *Section 3.6 – Eligibility Requirements for Mental Health Nurses*); **AND**
- the consistency of terms and conditions for the engagement of mental health nurses with

relevant state or territory legislation; **AND**

- the maintenance of minimum levels of contact with patients with a severe mental health disorder that meet their individual client requirements (this may include telephone contact); **AND**
- the presence of formal protocols for managing a patient's mental health care under this initiative, including:
 - a GP Mental Health Care Plan for general practitioners or equivalent plan for psychiatrists, developed in collaboration with the mental health nurse (these plans must include specific reference to the roles and responsibilities of both the nurse and the treating medical practitioner)
 - mental health nurse assessment of eligible patients at entry, every 90 days and at exit from the initiative using the Health of the Nation Outcome Scales (HoNOS), including the Child and Adolescent (HoNOS-CA), Adult (HoNOS), and Older Person (HoNOS 65+) tools; **AND**
- the appropriate training of mental health nurses engaged in using the HoNOS (see Section 8.1 for further information); **AND**
- agreement to notify Medicare Australia of any changes to eligibility of the organisation within **14 calendar days** for Incentive Payments or **28 calendar days** for the Establishment Payment (see Section 3.11 – Payments to Eligible Organisations); **AND**
- the presence of clear and agreed role descriptions for mental health nurses engaged, which are consistent with the role and functions of a mental health nurse and the legislative framework of the eligible organisation's state or territory; **AND**
- the presence of clear lines of clinical accountability (specified in writing), including the responsibilities of the mental health nurse and participating medical practitioner; **AND**
- the presence of protocols in relation to the safety of staff in all service provision settings (eg clinic, patient's home, travelling); **AND**
- the availability of dedicated working spaces within the clinic or as appropriate for engaged mental health nurses during working hours; **AND**
- the availability of clinical care oversight, including regular reviews of care provided by mental health nurses; **AND**
- the presence of support systems for mental health nurses, such as access to training and peer mentoring opportunities; **AND**
- the maintenance of records relating to mental health nurse engagement; **AND**
- the maintenance of case records by engaged mental health nurses that record activities undertaken. (**Important:** these activities must be consistent with the roles described under Section 3.7 – Functions of the Mental Health Nurse); **AND**
- the services provided by mental health nurses will be at little or no cost to the patient; **AND**
- agreement to provide Medicare Australia with reporting data as detailed in Section 3.10 – Monitoring and Reporting.

If requested, the organisation must provide evidence of the above to Medicare Australia under the Medicare Australia *Mental Health Nurse Incentive Program Audit Program*.

3.9.1 Divisions of General Practice – Requirements for Eligibility

Divisions of General Practice are required to ensure organisations using the services of a mental health nurse engaged by the Division meet Mental Health Nurse Incentive Program eligibility requirements as detailed in Section 3.9 – Requirements for Eligible Organisations.

3.10 Monitoring and Reporting

Eligible organisations will be required to provide the following data to Medicare Australia with each application:

3.10.1 Organisational Information

- *Mental Health Nurse Incentive Program* identification number
- name of organisation
- number of mental health nurses engaged

3.10.2 Sessional Information

- session number
- data of session
- am or pm
- full eight digit provider number
- provider name
- mental health nurse name and date of birth
- shared employment arrangement
- mental health nurse engagement date
- mental health nurse credentials
- locality/suburb of service outlet(s)
- postcode of service outlet(s)
- number of sessions provided per nurse

3.10.3 Patient Information

- Medicare card number or DVA Veteran file number
- patient name
- sex
- data of birth
- patient's current residential postcode
- shared care health plan
- number of face-to-face consultations per patient.

3.11 Payments to Eligible Organisations

Payments will be made before the end of the month that immediately follows the month in which the claim form has been received by Medicare Australia. For example, if a claim form is received by Medicare Australia on 20 July 2008, the payment will be made to the organisation by 31 August 2008. Payments will reflect the number of sessions detailed in the claim form.

Claim forms will be accepted up to six months following the date the session being claimed was undertaken. Claims lodged over six months following the corresponding session date will not be processed for payment.

All claims will be paid at the rate of \$240 (GST inclusive) per session. This figure is intended to be applied to mental health nurse salary and on-costs, including personal and recreation leave entitlements.

For services in rural and remote areas of Australia, a 25 per cent (25%) loading (GST inclusive) will be applied to the sessional payment. Rural and remote services are those located in 'very remote', 'remote' and 'outer regional' areas as defined by the Australian Standard Geographic Classification (ASGC) Remoteness Classification.

The loading will apply in respect to the locality of a nurse's 'service outlet' for that day (that is the physical location of the office or clinic where the nurse is based). **Important:** services provided at the patient's home are considered to be services provided from the nurse's service outlet for that day.

Organisations engaging a nurse under the *Mental Health Nurse Incentive Program* will qualify for a one-off Establishment Payment of up to \$10,000 to cover the upfront costs of engaging the nurse. For organisations engaging a nurse for between five and ten sessions per week over a six month period a payment of \$10,000 is available and for organisations engaging a nurse for one to four sessions a week, over a six month period, the payment is \$5000.

Note: one payment is available per organisation, not per nurse engaged. Organisations only qualify for the establishment payment if they have engaged the nurse in an employment arrangement.

The retention of a nurse engaged by another organisation (such as a Division of General Practice) does not constitute an employment arrangement for the purpose of an establishment payment. *(Please note – the Australian Government Department of Health and Ageing have confirmed that Divisions of General Practice ARE eligible for the establishment payment. The above statement is meant to guard against both the general practice AND the Division both claiming the establishment payment for the engagement of the same nurse).* The payment will be assessed on the total number of sessions conducted over a week by the total number of nurses engaged i.e. two nurses conducting four sessions each (total of eight) will qualify for a \$10,000 payment.

3.12 Questions and Answers

3.12.1 How Does an Organisation Apply for this Payment?

The Mental Health Nurse Incentive Program commenced on 1 July 2007. Organisations meeting the eligibility criteria detailed in Section 3.4 – Eligible Organisations and Section 3.9 – Requirements for Eligible Organisations can apply for the Mental Health Nurse Incentive Program at any time.

*The application form is available at www.medicareaustralia.gov.au then go to **For Health Professionals > Incentives & Allowances**. The completed form must be signed by the authorised contact person for the organisation and returned to Medicare Australia.*

3.12.2 Who is an Authorised Contact Person?

The authorised contact person is an individual authorised by the owner of the organisation to advise Medicare Australia of changes to the service and is the person to whom all correspondence is addressed.

3.12.3 How Will the Payment be Made?

Eligible organisations are required to lodge their completed application form with Medicare Australia. If the application is successful, a letter of acceptance and a claim form will be issued to the eligible organisation. Payments will occur monthly upon receipt of the completed claims form as detailed in Section 3.11 – Payments to Eligible Organisations. Medicare Australia will make the monthly payments via electronic funds transfer to a designated financial institution account.

3.12.4 How Does an Organisation Apply for the Establishment Payment?

Medicare Australia will advise all eligible organisations of the process for claiming the payment. Upon engagement of a mental health nurse under Mental Health Nurse Incentive Program, an organisation must complete the Establishment Payment application form and submit evidence of engagement of a mental health nurse to Medicare Australia. Approval of these documents will trigger payment of the Establishment Payment.

3.12.5 How Does the ASGC Differ from RRMA?

The Rural Remote Metropolitan Area (RRMA) classification is based on 1991 Census data and is no longer used in new programs undertaken by the Australian Government Department of Health and Ageing. Some older programs do continue to use RRMA. Some parts of Australia considered rural and remote under RRMA may not be considered rural or remote under the ASGC. Organisations may appeal, through Medicare Australia, to have the ASGC rural and remote loading applied if they can demonstrate that at least 80 per cent (80%) of their patients live in an ASGC rural, remote or very remote area.

3.13 Assistance

If you would like more information on the Mental Health Nurse Incentive Program:

- call Medicare Australia on **1800 222 032** (between 8.30 am–5.00 pm ACST); **OR**
- visit <http://www.medicareaustralia.gov.au/> then go to **For health professionals > Incentives & Allowances**; **OR**
- visit <http://www.health.gov.au/> then go to **For Consumers > Education and Prevention > Mental health**; **OR**
- visit <http://www.acmhn.org/> then go to **MHN Incentive Program**.

4.0 Models of Service Delivery

There are a number of different models of service delivery for the *Mental Health Nurse Incentive Program* that are active across the country. This document will focus on the four most common, but this list is not exhaustive, nor is it rigid. There may well be other examples where organisations have a mix of the following models, or are implementing a different model altogether.

The most prominent difference between the models discussed below is who 'employs' the mental health nurse. The 'employment arrangement' chosen more or less dictates the role of all key stakeholders involved, as the 'employer' is usually the 'eligible organisation' that is responsible for ensuring the *Mental Health Nurse Incentive Program* runs according to the parameters set out by the Australian Government Department of Health and Ageing (see Section 3.9 – Requirements for Eligible Organisations). An overview of each of the key models is given in Sections 4.1, 4.2, 4.3 and 4.4, as well as a table summarising the variations of each of the models, to facilitate comparisons.

4.1 Model 1 - Shared Employment Arrangements

The defining characteristic of 'shared employment arrangements', as used for the Mental Health Nurse Incentive Program, is a collaboration between state mental health services and participating private organisations. Whilst state mental health services are not eligible for Incentive payments as part of the Mental Health Nurse Incentive Program, they are able to make the services of their mental health nurses available to participating private organisations, on a fee for service basis. In the example below, the participating private organisation is a Division of General Practice, but a general practice could enter into a similar arrangement with an agreeable mental health service.

Under 'shared employment arrangements', the mental health nurse remains an employee of the state mental health service, retaining any salary packaging, professional development, leave and superannuation entitlements. The 'fee' charged by the state mental health service, for the use of the mental health nurse, must cover salary and on-costs, including personal and recreational leave entitlements.

The following table articulates the roles each of the key stakeholders play in this 'shared employment arrangements' model. This information has been summarised and adapted from collaborative arrangements between the 'Ipswich and West Moreton Division of General Practice' and the 'West Moreton South Burnett Health Service District'. In this particular example, many of the responsibilities that would normally sit with the 'eligible organisation' (the Division of General practice) actually sit with the 'employer' (the public mental health service). Given that the mental health nurse remains employed by state health services, the state health service actually retains responsibility for a number of requirements (eg salary and all entitlements, clinical supervision and support systems) that would normally sit with the Division of General Practice.

Whilst this table discusses the various roles and responsibilities of the stakeholders in practice, it should remain clear, that from Medicare Australia's perspective, the 'eligible organisation' (namely the Division of General practice) is **ultimately responsible** for all requirements listed in Section 3.9.

Model 1 – Shared Employment Arrangements	
Eligible Organisation	Division of General Practice
Mental Health Nurse Employer	State Mental Health Service
Referral Mechanism	<p>There are two main options:</p> <ul style="list-style-type: none"> • Either the GP can make a referral to the Division of General Practice, who is then in a position to allocate the nurse to various practices, depending on demand. Keeping in mind the expectation that clients will continue to see the mental health nurse for extended periods, it will not take long for the nurse to reach his/her maximum caseload. • The other option is for the GP to refer directly to the mental health nurse, either when the nurse is at the practice, via mobile phone, or using a booking sheet the nurse makes available at reception. Similar to the previous process, it will not take long before the nurse is at maximum capacity, and future referrals may have to be triaged or simply added to a wait list. <p>Whichever referral process is chosen will need to be clearly indicated in the contract between the Division of General practice and the participating general practices.</p>
Location of Services	<ul style="list-style-type: none"> • In most cases, consultations would occur at the general practice. However, in some cases, where safe and appropriate, the nurse may be required to see patients in a different location (eg patient's home). It would be the responsibility of either the Division of General Practice or the general practice itself, to ensure the nurse's safety when visiting patients in a different location. These responsibilities would be determined in the contract(s) between the state public mental health service, the Division of General Practice and the individual general practices.
Memorandum of Understanding / Contract	<ul style="list-style-type: none"> • Contract between the state mental health service and the Division of General Practice, outlining details of the secondment. • Contract between Division of General Practice and the mental health nurse, outlining details of work conditions, deliverables and implementation process for the Program, whilst working in the primary care setting. • Contract between Division of General Practice and individual general practices, outlining the services to be provided to the practice and its patients.

continue...Model 1 – Shared Employment Arrangements

<p>Role of Division of General Practice</p>	<ul style="list-style-type: none"> • Responsible for management of the Mental Health Nurse Incentive Program, including financial management, ensuring that enough income is generated via Incentive payments to cover the 'fee' charged for use of the mental health nurse, as well as any program administration costs incurred by the Division of General Practice. • Responsible for engaging general practices to participate in the Mental Health Nurse Incentive Program, including preparation of the practice to ensure readiness (eg adequate case load, appropriate working spaces, administrative support, emergency procedures, IMIT support with remote access to state mental health service systems); • Responsible for ensuring that GP Mental Health Care Plans are in place for each patient seen by the mental health nurse.
<p>Role of General Practitioner</p>	<ul style="list-style-type: none"> • Responsible for providing a safe and appropriate consulting space for the mental health nurse; • Responsible for appropriate referrals to the mental health nurse; • Responsible for completion of the GP Mental Health Care Plan, (developed in collaboration with the mental health nurse if appropriate), which clearly articulates the roles and responsibilities of both the nurse and the medical practitioner; • Responsible for maintenance of, and allowing access to, patient files to ensure that activities and interventions are recorded.
<p>Role of Mental Health Nurse</p>	<ul style="list-style-type: none"> • Responsible for all aspects of client management, including ensuring essential documentation and patient eligibility criteria are met, and transitioning clients into and out of the Program; • Responsible for managing case load and case mix – ensuring enough time is allocated for client consultation, follow up, coordination, clinical supervision, professional development and reporting; • Responsible for communicating with other medical and allied health personnel regarding the client; • Responsible for communicating with administrative staff (at the general practice and/or the Division of General Practice) regarding scheduling, appointment management, and availability; • Responsible for the timely completion and lodgement of Mental Health Nurse Incentive Program sessional claim forms to ensure Incentive payments are received.

continue...Model 1 – Shared Employment Arrangements	
Role of Public Mental Health Service	<ul style="list-style-type: none"> Given that the mental health nurse remains employed by the mental health service, the service is responsible for maintenance of all existing employment conditions for the seconded nurse; Responsible for the clinical supervision of the mental health nurse; Responsible for the provision of remote access to state mental health service systems and data collection programs (eg HoNOS, CESA, MHI) Responsible for the risk, should the mental health nurse not manage their workload effectively.
Benefits – As Compared to other Models (please note – not all benefits are listed, only those that are specific to this 'shared employment arrangements' model)	<ul style="list-style-type: none"> A collaborative working arrangement with a state mental health service means the Division or General Practice may have access to the services of mental health nurses where others do not; With the mental health nurse remaining employed by the state mental health service, they have access to professional development and clinical supervision that might otherwise be difficult to access and/or very costly; With the nurse having experience with the state mental health service, and remaining linked to the service through-out the Program, they are well placed to refer into and navigate the system that primary care practitioners often struggle with; Strong links with the state mental health service may have positive flow-on effects to other areas, such as shared mental health education sessions, increased access to psychiatrists under a consultant-liaison model, and shared-care programs (eg Clozapine).
Barriers – As Compared to other Models (please note – not all barriers are listed, only those that are specific to this 'shared employment arrangements' model)	<ul style="list-style-type: none"> Mental health nurses from the state mental health service may have had little experience working within the primary care setting; With two organisations managing the mental health nurse role (namely the Division of General Practice and the state mental health service), there is the potential for confusion and/or disagreement on a number of issues. Clearly articulated contracts, or the opportunity to review contracts should the need arise, should alleviate these concerns; With mental health nurses seconded away from the state mental health service, there is a risk for a shortage of skilled staff within the mental health service. These risks will need to be considered before a state mental health service agrees to a secondment of one (or more) their mental health nurses.
Income Available	<ul style="list-style-type: none"> Establishment Payment – this payment is not available to the eligible organisation when the nurse is retained under 'shared employment arrangements'. If the eligible organisation engages the services of other nurses as employee's, then they can apply for the payment; Sessional Payments – all eligible claims are paid at \$240 per session (GST inclusive), with a session comprising 3.5 hours, and with a maximum of ten (10) sessions per week per nurse. A 25% loading is added for services provided in rural and remote areas of Australia (See section 3.11 for further information).

4.2 Model 2 – Direct Employment

Probably the simplest model of service delivery utilised within the Mental Health Nurse Incentive Program, the 'direct employment' model is in place where the general practice employs, or contracts directly, with the mental health nurse, to provide services at their practice, for a nominated number of sessions (anywhere from one to ten sessions per week). Under this model, the general practice has exclusive access to the mental health nurse during the contracted sessions. The mental health nurse could of course make his/her services available to a number of practices, where in effect, he/she would have multiple employers and contracts in place (eg Practice X might employ the nurse for morning sessions five days per week, and Practice Y might employ the nurse for afternoon sessions five days per week). The rate of pay would be negotiated between the mental health nurse and each practice.

The following table articulates the roles each of the key stakeholders play in this 'direct employment' model. This information has been summarised and adapted from the arrangements in place between a mental health nurse and the Kedron-Wavell Medicentre at Kedron, on the north side of Brisbane.

Model 2 – Direct Employment	
Eligible Organisation	General Practice
Mental Health Nurse Employer	General Practice
Referral Mechanism	Given that the nurse is employed by the practice, the number of sessions and days of work would be clearly understood by all involved. The GP could either have scheduled meetings with the nurse (eg weekly), to discuss the referrals of new patients, or the GP could simply make a booking via the scheduling system that is in place via reception. With this model, there are increased opportunities for the GP to have both formal and informal conversations about new referrals, patient progress or the program in general.
Location of Services	In most cases, consultations would occur at the general practice. However, in some cases, where safe and appropriate, the nurse may be required to see patients in a different location (eg patient's home). It would be the responsibility of the general practice, as the nurse's employer, to ensure the nurse's safety when visiting patients in a different location. These responsibilities would be determined in the contract between the mental health nurse and the general practice.
Memorandum of Understanding / Contract	<ul style="list-style-type: none"> Contract between individual general practices and the mental health nurse, outlining details of work conditions, deliverables and implementation process for the Program, rate of pay and other entitlements.

continue...Model 2 – Direct Employment	
Role of Division of General Practice	<ul style="list-style-type: none"> • Nil for this model.
Role of General Practitioner	<ul style="list-style-type: none"> • As the eligible organisation, the general practice has overall responsibility for the management of the Mental Health Nurse Incentive Program, including applications to Medicare (for initial eligibility, the Establishment payment and ongoing sessional payments), mental health nurse recruitment, employment/contractual arrangements for the mental health nurse, provision of safe and appropriate consulting rooms, establishment of emergency protocols, provision of clinical supervision, required insurances and administrative support for the mental health nurse. • With regard to the referral of clients, the general practice also has responsibility for ensuring an adequate case load to meet the sessional requirements, ensuring only appropriate and eligible clients are referred to the nurse, ensuring that a GP Mental Health Care Plan is in place for each patient referred to the nurse, as well as the maintenance of, and allowing access to, patient files to ensure that activities and interventions are recorded. • Provision of suitable room
Role of Mental Health Nurse	<ul style="list-style-type: none"> • Responsible for all aspects of client management, including ensuring essential documentation and patient eligibility criteria are met, and transitioning clients into and out of the Program; • Responsible for managing case load and case mix – ensuring enough time is allocated for client consultation, follow up, coordination, clinical supervision, professional development and reporting; • Responsible for communicating with other medical and allied health personnel regarding the client; • Responsible for communicating with practice administrative staff regarding scheduling, appointment management, and availability; • Responsible for the timely completion and lodgement of <i>Mental Health Nurse Incentive Program</i> sessional claim forms to ensure Incentive payments are received.
Role of Public Mental Health Service	<ul style="list-style-type: none"> • Nil for this model.

continue...Model 2 – Direct Employment

Benefits – As Compared to other Models
(please note – not all benefits are listed, only those that are unique to this 'direct employment' model)

- Simple and clear lines of accountability, communication and management;
- With the nurse employed by the practice, the development of strong relationships with the GPs (and others) at the practice is likely. This increases the likelihood of shared learning, as well as gaining a stronger appreciation of each other's profession;
- In most cases, a practice that enters into a 'direct employment' relationship with their own mental health nurse, would be able to substantiate close to a full time work load for the nurse. Having a mental health nurse at a practice full time has far reaching benefits in terms of accessing the nurse for advice/opinion on other patients. Of course, the practice and the nurse would need to ensure that services rendered whilst participating in a session related to the Mental Health Nurse Incentive Program, were indeed for patients that were part of the Program;
- Practices who directly engage the services of a mental health nurse are eligible for the Mental Health Nurse Incentive Program Establishment payment (\$5,000 if the nurse is engaged for between 1 – 4 sessions per week, or \$10,000 if the nurse is engaged for five or more sessions per week).

Barriers – As Compared to other Models
(please note – not all barriers are listed, only those that are unique to this 'direct employment' model)

- The general practice is responsible for ensuring that they can substantiate the number of eligible patients required to sustain the mental health nurse for the amount of employed/contracted sessions. If the situation arises, where the practice does not have enough eligible patients to refer to the nurse, yet they have engaged the nurse for a set number of sessions per week (as per the contract), then the practice is liable for the cost of paying the nurse, but would be unable to recoup costs through a sessional payment. The practice needs to weigh up this risk prior to taking on a nurse under a 'direct employment' model. In this situation, where the practice cannot reliably predict the number of eligible patients they have, the Division of General Practice would be better placed to employ the nurse, to ensure that supply always matches demand.

Income Available

- Establishment Payment – to cover the upfront costs of engaging a mental health nurse, the general practice is eligible for a one-off \$5,000 payment if they have engaged a nurse for between one and four sessions per week, and \$10,000 if the nurse is engaged for five sessions or more. The payment is per organisation, not per nurse, and the nurse must be engaged for at least a six-month period;
- Sessional Payments – all eligible claims are paid at \$240 per session (GST inclusive), with a session comprising 3.5 hours, and with a maximum of 10 sessions per week per nurse. A 25% loading is added for services provided in rural and remote areas of Australia (See section 3.11 for further information).

4.3 Model 3 – Division of General Practice Employment

The third model of service delivery that is quite popular in Queensland, is where the Division of General Practice employs the mental health nurse, and services are allocated to individual general practices based on demand. The Division of General Practice enters into contractual agreements with participating practices, and is responsible for ensuring that both the Division, AND any participating practices, meet the criteria for 'eligible organisations', as outlined in the *Mental Health Nurse Incentive Program – Program Guidelines*.

The Mental Health Nurse may travel to the general practice to provide the services to patients, or they may work out of Division consulting rooms, similar to the way many allied health providers work under the Access To Allied Psychological Services (ATAPS) Program. Unlike the ATAPS Program though, patients referred to mental health nurses under the *Mental Health Nurse Incentive Program* are expected to require the services of the nurse for extended periods of time.

The following table articulates the roles each of the key stakeholders play within this 'Division of General Practice Employment' model. This information has been summarised and adapted from the collective arrangements of a number of Divisions of General Practice in Queensland who are already utilising this model.

Model 3 – Division of General Practice Employment	
Eligible Organisation	Division of General Practice
Mental Health Nurse Employer	Division of General Practice
Referral Mechanism	<p>There are two main options:</p> <ul style="list-style-type: none"> • GPs from participating practices notify the Division of General Practice that they wish to make a referral to the mental health nurse. The Division then allocates the nurse's services, depending on demand. The mental health nurse may travel to the general practice to see patients, or they may provide services from the Division's consulting rooms. Keeping in mind the expectation that patients will continue to see the mental health nurse for extended periods, it will not take long for the nurse to reach his/her maximum caseload. • The other option is for the GP to refer directly to the mental health nurse, either when the nurse is at the practice, via mobile phone, or using a booking sheet the nurse makes available at reception. Although this second option may be more suitable for the referring practitioner (being able to just talk with the nurse whilst they are at the practice), it will rely on the nurse relaying referral information back to the Division to ensure that the Division is aware of all referrals and sessions. Similar to the previous process, it will not take long before the nurse is at maximum capacity, and future referrals may have to be triaged or simply added to a wait list. • Whichever referral process is chosen will need to be clearly indicated in the contract between the Division of General practice and the participating general practices.

continue...Model 3 – Division of General Practice Employment

<p>Location of Services</p>	<ul style="list-style-type: none"> • In most cases, consultations would occur at the general practice, unless the Division chooses to use dedicated consulting rooms that may already be in place for allied health sessions. However, in some cases, where safe and appropriate, the nurse may be required to see patients in a different location (eg patient's home). As the employer of the nurse, it would be the responsibility of the Division of General Practice to ensure the nurse's safety when visiting patients in a different location.
<p>Memorandum of Understanding/ Contract</p>	<ul style="list-style-type: none"> • Contract between Division of General Practice and the mental health nurse, outlining details of work conditions, deliverables and implementation process for the Program whilst working in the primary care setting. • Contract between Division of General Practice and individual general practices, outlining the services to be provided to the practice and its patients.
<p>Role of Division of General Practice</p>	<ul style="list-style-type: none"> • Responsible for overall management of the Mental Health Nurse Incentive Program, including financial management, ensuring that enough income is generated via Incentive payments to cover the nurse's salary as well as any program administration costs incurred by the Division of General Practice; • Responsible for engaging general practices to participate in the Mental Health Nurse Incentive Program, including preparation of the practice to ensure readiness (eg adequate case load, appropriate working spaces, administrative support, emergency procedures, IMIT support); • Responsible for ensuring that GP Mental Health Care Plans are in place for each patient seen by the mental health nurse.
<p>Role of General Practitioner</p>	<ul style="list-style-type: none"> • Responsible for providing a safe and appropriate consulting space for the mental health nurse; • Responsible for appropriate referrals to the mental health nurse; • Responsible for completion of the GP Mental Health Care Plan, (developed in collaboration with the mental health nurse if appropriate), which clearly articulates the roles and responsibilities of both the nurse and the medical practitioner; • Responsible for maintenance of, and allowing access to, patient files to ensure that activities and interventions are recorded.

continue...Model 3 – Division of General Practice Employment

<p>Role of Mental Health Nurse</p>	<ul style="list-style-type: none"> • Responsible for all aspects of client management, including ensuring essential documentation and patient eligibility criteria are met, and transitioning clients into and out of the Program; • Responsible for managing case load and case mix – ensuring enough time is allocated for client consultation, follow up, coordination and reporting; • Responsible for communicating with other medical and allied health personnel regarding the client; • Responsible for communicating with administrative staff (at the general practice and/or the Division of General Practice) regarding scheduling, appointment management, and availability; • Responsible for the timely completion and lodgement of Mental Health Nurse Incentive Program sessional claim forms to ensure Incentive payments are received.
<p>Role of Public Mental Health Service</p>	<ul style="list-style-type: none"> • Nil for this model.
<p>Benefits – As Compared to other Models (please note – not all benefits are listed, only those that are specific to this 'Division of General Practice employment' model)</p>	<ul style="list-style-type: none"> • Having the Division of General Practice as the employer allows more flexibility for supply to meet demand, rather than the nurse being tied to a particular practice; • Mental health nurses that are employed by Divisions of General Practice, and practice out of a dedicated mental health clinic, will likely find themselves working within a multidisciplinary team, made of up ATAPS allied health professionals, other mental health nurses and drug and alcohol support workers. This allows opportunities for increased clinical support and networking, as well as gaining an appreciation of alternate professions; • Employing a mental health nurse will allow the Division of General Practice to be more responsive to its members needs, by being able to support GPs with their patients with mild to moderate mental health disorders (ATAPS and Better Access Programs), through to severe and chronic mental health disorders (Mental Health Nurse Incentive Program).

continue...Model 3 – Division of General Practice Employment

Barriers – As Compared to other Models (please note – not all barriers are listed, only those that are specific to this 'Division of General Practice employment' model)

- As the employer and 'eligible organisation', the Division of General Practice is responsible for ensuring support systems for the mental health nurse are in place, including access to training, professional development and peer mentoring opportunities. Whilst there may be some Divisions that are more prepared in this area than others, there will be a number of divisions for whom this may be an issue;
- Being employed by a Division of General Practice, some nurses may feel some conflict when sharing their time across clinical work and administrative work. It has been the experience of a number of allied health professionals who deliver clinical services as part of the ATAPS and Better Access Programs, that it is often difficult to allocate time to administrative duties, when patients are in need of ongoing support. It would be the responsibility of the Division of General Practice, to ensure that the nurse was supported to allow enough time for both important parts of the role.

Income Available

- Establishment Payment – to cover the upfront costs of engaging a mental health nurse, the Division of General Practice is eligible for a one-off \$5,000 payment if they have engaged a nurse for between 1 – 4 sessions per week, and \$10,000 if the nurse is engaged for five sessions or more. The payment is per organisation, not per nurse, and the nurse must be engaged for at least a 6-month period. If the Division engages the services of more than one nurse, then the total number of sessions worked by all nurses dictates the payment. (eg if two nurses are both employed for four sessions per week, making a total of eight sessions, the Division would receive the \$10,000 Establishment payment);
- Sessional Payments – all eligible claims are paid at \$240 per session (GST inclusive), with a session comprising 3.5 hours, and with a maximum of ten (10) sessions per week per nurse. A 25% loading is added for services provided in rural and remote areas of Australia (See section 3.11 for further information)

4.4 Model 4 – Division of General Practice Contract

The final model of service delivery to be detailed in this document is where the Division of General Practice contracts the services of a Mental Health Nurse, practicing as a consultant/provider in their own right. An area with enormous growth potential for mental health nurses, this model recognises the skill and expertise of a credentialed mental health nurse, as a specialist provider, in much the same way that psychologists and other allied health professionals have been working for a number of years. Essentially, the Division of General Practice recruits the mental health nurse, and engages in a contractual relationship whereby the nurse is paid for the sessions he/she works. The Division is responsible for recruiting the general practices, however once a nurse is assigned to a practice, he/she operates in the same way as any private contractor, accepting referrals, managing their workload, rebooking appointments and essentially running their own business. The nurse manages his/her own time and workload, and simply submits a claim to the Division of General Practice for the sessions completed. Depending on demand, the nurse may be assigned to just one practice, or he/she may be assigned to multiple practices. The nurse may also retain employment with another employer (eg Queensland Health) for a number of days per week, and work under the *Mental Health Nurse Incentive Program* for anywhere between one and ten sessions per week.

The most salient difference between this 'contractor' model, and the Division of General Practice 'employment' model, is that the nurse is not salaried, and therefore the risk to the Division of ensuring that Medicare claims are enough to cover salary, virtually disappears. The Division agrees on a sessional payment to the nurse, and the Division submits the Mental Health Nurse Incentive Payment claim form to Medicare to recoup monies paid to the nurse. The nurse is free to manage his/her time according to his/her needs, and may actually work three sessions on one particular day, in order to have time available the following day to attend some professional development activity. As is the case with other contractors and private providers, professional development is the responsibility of the provider, and therefore the mental health nurse organises and pays for these activities according to his/her needs.

The following table articulates the roles each of the key stakeholders play in this 'Division of General Practice Contract' model. This information has been summarised and adapted from the arrangements in place between a number of mental health nurses and Brisbane South Division of General Practice.

Model 4 – Division of General Practice Contract	
Eligible Organisation	Division of General Practice
Mental Health Nurse Employer	Division of General Practice
Referral Mechanism	<ul style="list-style-type: none"> Once the mental health nurse is assigned to his/her practice, the GP is able to refer directly to the nurse, either using the clinical booking system, via mobile phone, or using a booking sheet the nurse makes available at reception.
Location of Services	<ul style="list-style-type: none"> In most cases, consultations would occur at the general practice, however, in some cases, where appropriate, the nurse may be required to see patients in a different location (eg patient's home). As the organisation contracting the nurse, it would be the responsibility of the Division of General Practice to develop guidelines for home visits.
Memorandum of Understanding / Contract	<ul style="list-style-type: none"> Contract between Division of General Practice and the mental health nurse, outlining details of work conditions, deliverables and implementation process for the Program whilst working in the primary care setting. Contract between Division of General Practice and individual general practices, outlining the services to be provided to the practice and its patients.
Role of Division of General Practice	<ul style="list-style-type: none"> Responsible for overall management of the Mental Health Nurse Incentive Program, including recruitment and retention of nurses, HRM process and payroll services; Responsible for engaging general practices to participate in the Mental Health Nurse Incentive Program, including preparation of the practice to ensure readiness (eg adequate case load, appropriate working spaces, administrative support, emergency procedures, IMIT support); Responsible for submitting sessional claim forms to Medicare.
Role of General Practitioner	<ul style="list-style-type: none"> Responsible for providing a safe and appropriate consulting space for the mental health nurse; Responsible for appropriate referrals to the mental health nurse; Responsible for completion of the GP Mental Health Care Plan, (developed in collaboration with the mental health nurse if appropriate), which clearly articulates the roles and responsibilities of both the nurse and the medical practitioner; Responsible for maintenance of, and allowing access to, patient files to ensure that activities and interventions are recorded.

continue...Model 4 – Division of General Practice Contract	
Role of Mental Health Nurse	<ul style="list-style-type: none"> • Responsible for all aspects of client management, including ensuring essential documentation and patient eligibility criteria are met, and transitioning clients into and out of the Program; • Responsible for managing case load and case mix – ensuring enough time is allocated for client consultation, follow up, coordination and reporting; • Responsible for communicating with other medical and allied health personnel regarding the client; • Responsible for communicating with practice and administrative staff (at the general practice) regarding scheduling, appointment management, and availability; • Responsible for the timely completion and lodgement of Mental Health Nurse Incentive Program sessional claim forms to ensure Incentive payments are received; • Responsible for identifying and completing professional development activities appropriate to their needs.
Role of Public Mental Health Service	<ul style="list-style-type: none"> • Nil for this model.
Benefits – As Compared to other Models (please note – not all benefits are listed, only those that are specific to this 'Division of General Practice contract' model)	<ul style="list-style-type: none"> • Being located at the General Practice, the mental health nurse has the opportunity to be intimately responsive to the needs of the practice, seeing patients as and when necessary, and supporting the all practice staff to become more aware of the needs of people with mental illness; • For the mental health nurse, this contractor model recognises the strengths of the mental health nursing profession, and values the unique input mental health nurses can have as specialist mental health clinicians; • For the mental health nurse, this contractor model also allows greater flexibility in determining work-load and work-hours, with the nurse in control of his/her business of practicing in his/her profession; • For the Division of General Practice, this contractor model virtually eliminates the risk of carrying the nurses salary whilst waiting and hoping that all sessional claims are honoured by Medicare (in order to cover salary costs). Nurses submit claims to the Division of General Practice for the sessions worked. If a session is not worked, then no payment needs to be paid to the nurse.

continue...Model 4 – Division of General Practice Contract

<p>Barriers – As Compared to other Models <i>(please note – not all barriers are listed, only those that are specific to this 'Division of General Practice contract' model)</i></p>	<ul style="list-style-type: none"> • Not so much a barrier, but something that the Division of General Practice needs to consider when recruiting nurses, is the ability of the nurse to work as an independent practitioner. This model dictates that the Division should recruit nurses who have previously practiced as a 'nurse grade 7' or 'N04' level, to ensure that they can function as independent practitioners, managing their own case-mix and case-load, recognising and acting on their professional development needs, as well as the tending to the administrative requirements of functioning as an independent provider. These requirements will essentially reduce the pool of applicants available to a Division; • For the mental health nurse, there is less financial security with this contractor model, as compared with the 'Division of General Practice employment model', as payments are only made for sessions completed and hours worked.
<p>Income Available</p>	<ul style="list-style-type: none"> • Establishment Payment – to cover the upfront costs of engaging a mental health nurse, the Division of General Practice is eligible for a one-off \$5,000 payment if they have engaged a nurse for between 1 – 4 sessions per week, and \$10,000 if the nurse is engaged for five sessions or more. The payment is per organisation, not per nurse, and the nurse must be engaged for at least a 6-month period. If the Division engages the services of more than one nurse, then the total number of sessions worked by all nurses dictates the payment. (eg if two nurses are both employed for four sessions per week, making a total of eight sessions, the Division would receive the \$10,000 Establishment payment); • Sessional Payments – all eligible claims are paid at \$240 per session (GST inclusive), with a session comprising 3.5 hours, and with a maximum of ten (10) sessions per week per nurse. A 25% loading is added for services provided in rural and remote areas of Australia (See section 3.11 for further information)

5.0 SWOT Analyses

A SWOT analysis, covering the strengths, weaknesses, opportunities and threats has been undertaken from the perspective of each of the key stakeholders. In the case where the comments correspond to the adoption of a particular model (eg shared employment arrangements), this is clearly stated. The stakeholders covered include patients/clients, GPs, mental health nurses, Divisions of General Practice and public mental health services.

5.1 SWOT Analysis – Patients/Clients

Strengths	Weaknesses
<ul style="list-style-type: none"> • Little or no cost to access specialist mental health treatment; • Location of services is flexible to meet the needs of the patient; • Single point of contact for patients to access other key services (part of the coordination role the nurse can provide); • No limit to number of consultations available, for as long as the patient remains eligible; • Mental health and physical health needs can be met as part of overall care; • Family and carers are involved in the care, if appropriate; • Reduced stigma of seeking treatment, as services are accessed within the community, rather than at a mental health service; • Nurse maintains open lines of communication with other care providers (eg GP, psychiatrist, allied health provider) to ensure all care givers are aware of current status and situation. 	<ul style="list-style-type: none"> • If accessing a mental health nurse via the Mental Health Nurse Incentive Program, the patient is unlikely to be able to choose their provider. The likelihood of this would be the same regardless of the model of service delivery adopted.
Opportunities	Threats
<ul style="list-style-type: none"> • For patients to regain control of their life, and reconnect with their community; • A focus on holistic care, covering physical, social, emotional and psychological wellbeing; • Giving patients an opportunity to fully engage in their own care, via a coordinated care plan. • Mainstreaming access to GPs. 	

5.2 SWOT Analysis – General Practitioners

Strengths	Weaknesses
<ul style="list-style-type: none"> • Access to specialist mental health treatment for their patients; • Support and advice from the mental health nurse, both formally and informally. The opportunity to access this support and advice would be increased if the nurse was located at the General Practice; • Improved time efficiency; • Clinical collaboration is facilitated with a mental health nurse working within the practice; • Reduced need to refer to public mental health services (which can sometimes be a frustrating and unreliable process); • Increased access to professional networks and services; • Clinical support (from mental health nurse) in preparation of the GP Mental Health Care Plan; • Increased confidence that the patients are actually receiving the care they need. 	<ul style="list-style-type: none"> • The mental health nurse requires dedicated working spaces during working hours, however consulting room availability at the practice may be limited (this is not an issue if the nurse is employed by the Division of General Practice and practicing out of Division consulting rooms); • Retrospective sessional payments requires the practice to carry the nurse's salary for one (1) month (only an issue for the GP if the nurse is directly employed by the practice); • The ongoing monthly claims process is onerous and time consuming (only an issue for the GP if the nurse is directly employed by the practice); • Recruitment of the mental health nurse is time consuming and not always fruitful (only an issue for the GP if the nurse is directly employed by the practice).
Opportunities	Threats
<ul style="list-style-type: none"> • Improved mental and physical health outcomes for the GP's patients; • Increased opportunity to gain a greater awareness and understanding of the role of mental health nurses. Vice versa is true as well; • Opportunity for the GP to 'free-up' some time, by referring patients onto the mental health nurse, rather than treating the patient themselves; • Opportunity for the GP to gain further knowledge in the areas of diagnosis and treatment interventions, care coordination and management, and allied health and community support services. 	<ul style="list-style-type: none"> • If the mental health nurse is engaged under a 'direct employment' model, the practice carries the risk for the nurse's salary. Regular monthly payments are not guaranteed, but rather depend on the sessions detailed on the monthly claim form. Some claims are rejected without explanation, presumably due to Medicare deeming the session as not meeting the requirements; • If the mental health nurse is engaged under a 'direct employment' model, the practice carries the risk for the nurse's salary. If the practice cannot substantiate enough referrals for the nurse, then sessional payments may not be enough to cover the nurse's agreed salary. • A shortage of mental health nurses in the state prepared to work in the primary care setting.

5.3 SWOT Analysis – Mental Health Nurses

Strengths	Weaknesses
<ul style="list-style-type: none"> • Autonomy of the role, with nurses able to utilise their full range of skills and knowledge as a specialist mental health clinician; • Variety of the role, with nurses expected to manage a typical case load of patients who have low, medium and high care needs; • Flexibility of the role, with nurses able to work part time in the Program, as well as maintaining links with their previous role (most often public mental health services); • Recognition of the important role that mental health nurses play as a primary care provider; • Increased access to professional networks and services; • Clinical support (from GP) in preparation of the GP Mental Health Care Plan. 	<ul style="list-style-type: none"> • Mental health nurses engaged under the <i>Mental Health Nurse Incentive Program</i> must be credentialed with the Australian College of Mental Health Nurses by 31 December 2009. Whilst the credentialing program may well be seen as a strength of the Mental Health Nurse Incentive Program, it has been overwhelmingly viewed as negative, given the limited opportunities and time to become credentialed; • If a nurse is engaged under the 'direct employment' model, and resigns from a position with public mental health services to do so, then the nurse may be forfeiting entitlements, easy access to professional development and professional networking, clinical care oversight of cases, and higher rates of pay.
Opportunities	Threats
<ul style="list-style-type: none"> • The <i>Mental Health Nurse Incentive Program</i> provides mental health nurses with a new career path and job opportunities, expanding the scope and autonomy of their clinical practice; • The Program provides an increased opportunity to gain a greater awareness and understanding of the role of primary care providers (namely GPs, practice nurses, allied health providers). Vice versa is true as well; • Mental health nurses working in the primary care setting may have the option of also providing services within the ATAPS (Access to Allied Psychological Services) program. This provides further flexibility in the role, as well as an opportunity for increased income. 	<ul style="list-style-type: none"> • Professional isolation is a threat, particularly if the nurse is engaged under a 'direct employment' model with the practice. An agreed, supervision, professional development and peer networking plan within the contract between the nurse and the practice would need to be in place.

5.4 SWOT Analysis – Divisions of General Practice

Strengths	Weaknesses
<ul style="list-style-type: none"> • The Division is being responsive to the needs of its GP members; • The Division is being responsive to the needs of its community. 	<ul style="list-style-type: none"> • Retrospective sessional payments requires the Division of General Practice to carry the nurse’s salary for one (1) month (not an issue if the nurse is engaged under ‘shared employment arrangements); • The ongoing monthly claims process is onerous and time consuming; • Recruitment of the mental health nurse is time consuming and not always fruitful (not an issue if the nurse is engaged under ‘shared employment arrangements).
Opportunities	Threats
<ul style="list-style-type: none"> • The Division has the opportunity to expand the breadth of the multidisciplinary team that is providing services across the Division’s community; • If the nurse is engaged under ‘shared employment arrangements’ then the Division has a great opportunity to improve and grow its relationship with the public mental health service, allowing for improved access to the service, shared education sessions, and shared care programs; • Regardless of the model adopted, the Division has the opportunity to improve the uptake of GP Mental Health Care Items, which has implications for the health of the community, as well as reporting obligations. Referrals to the mental health nurse must be made in the context of a GP Mental Health Care Plan, and, if appropriate, the nurse can assist the GP in preparation of the plan. 	<ul style="list-style-type: none"> • If the mental health nurse is employed directly by the Division of General Practice, the Division carries the risk for the nurse’s salary. Regular monthly payments are not guaranteed, but rather depend on the sessions detailed on the monthly claim form. Some claims are rejected without explanation, presumably due to Medicare deeming the session as not meeting the requirements; • If the mental health nurse is employed directly by the Division of General Practice, the Division carries the risk for the nurse’s salary. If the referring practices cannot substantiate enough referrals for the nurse, then sessional payments may not be enough to cover the nurse’s agreed salary (please note, although this is a threat, this is unlikely if the Division has appropriately recruited practices to refer); • A shortage of mental health nurses across the state who are prepared to work in the primary care setting.

5.5 SWOT Analysis – Public Mental Health Services

Strengths	Weaknesses
<ul style="list-style-type: none"> • More appropriate referrals to the public mental health service, accompanied by improved referral information; • Reduced need to decline inappropriate referrals, which has only served to strain relationships between GPs and the mental health service. 	<ul style="list-style-type: none"> • If the public mental health service seconds a nurse under ‘shared employment arrangements’, they are essentially losing an experienced staff member to the primary care sector. Whilst this model has the potential for far reaching benefits, in the short term, the service is still losing an experienced mental health clinician.
Opportunities	Threats
<ul style="list-style-type: none"> • Strong potential for decreased referrals and/or admissions to the public mental health service (please note, this outcome is possible regardless of the model of service delivery chosen); • If the nurse is engaged under ‘shared employment arrangements’ then the mental health services has a great opportunity to improve and grow its relationship GPs and the primary sector in general. This may allow for more appropriate referrals, de-clogging of the system, shared education sessions, and shared care programs; • With increased capacity in the primary care sector, there is increased potential to effectively transition stable patients back to their communities; • By offering ‘shared employment arrangements’ as a career pathway, there is the potential to retain some mental health nurses who may otherwise be looking to move on from the service. 	<ul style="list-style-type: none"> • Potential loss of mental health nurses from the public mental health system, as some may choose to move across to the primary sector; • If the mental health nurse is engaged under ‘shared employment arrangements’, then the mental health service carries the risk for the nurse’s salary. Regular monthly payments (to the Division) are not guaranteed, but rather depend on the sessions detailed on the monthly claim form. Some claims are rejected without explanation, presumably due to Medicare deeming the session as not meeting the requirements. If the Division of General Practice cannot recoup sessional costs via the Incentive payment, then the program is at risk of failing; • If the mental health nurse is engaged under ‘shared employment arrangements’, then the mental health service carries the risk for the nurse’s salary. If the referring practices cannot substantiate enough referrals for the nurse, then sessional payments may not be enough to cover the ‘fee’ agreed as part of the ‘fee for service’ model, and the Program risks failure.

6.0 Financial Modelling

An important consideration for any organisation considering adopting the *Mental Health Nurse Incentive Program* is whether the Program will be financially viable for them. There are clear uncompromising costs involved in running the program, such as the nurse's salary, professional development fees, travel costs (if applicable), computer and/or mobile phone costs, and program administration costs. The primary source of income to offset these costs is via the sessional payment paid as part of the Mental Health Nurse Incentive Program. At the time of preparing this document, all claims are being paid at the rate of \$240 per session, with a 25% loading in rural and remote areas of Australia. Given that organisations can claim a maximum of ten (10) sessions per nurse per week, this equates to a maximum income of \$2,400 per week (without the loading). To obtain a maximum annual figure, we have assumed that the nurse can generate income for 44 weeks out of 52, allowing for four (4) weeks annual leave, two (2) weeks sick leave, and two (2) weeks spent attending professional development activities. This works out at a maximum income of \$105,600, which needs to cover all expenses associated with engaging a mental health nurse for the Program.

Some organisations may also choose to charge patients a small amount for accessing the mental health nurse. The Program Guidelines do not stipulate a maximum amount that can be charged, stating only "*the services provided by mental health nurses will be at little or not cost to the patient*" (see section 3.9). If we assume that some practices or Divisions of General Practice charge a similar amount to the co-payment in the ATAPS program, then this would equate to an additional \$300 per week, or \$13,200 per annum (based on \$15 co-payment, with an average of two (2) patients per session, multiplied by ten (10) sessions per week). It is unlikely though, given the type of patient, and the number of times that these patients are expected to access the nurse, that these figures will come into play.

The third source of income that does support the Program is the one-off establishment payment of up to \$10,000 to cover the up-front costs of engaging a mental health nurse. The establishment payment is paid to the eligible organisation, and is determined by the total number of sessions the nurse(s) is engaged for. For organisations engaging a nurse for between five and ten sessions per week, over a six-month period, the payment is \$10,000. For organisations engaging a nurse for between one and four sessions per week, over a six-month period, the payment is \$5,000. One payment is available per organisation, **not per nurse**, and the payment is assessed on the total number of sessions conducted over a week by the total number of nurses. That is, two nurses engaged for four sessions per week by the same organisation would attract a \$10,000 payment (total of eight sessions).

With these figures in mind, and discounting the potential income generated from co-payments, the maximum income that is available to support the Program is \$115,600. As clearly stated in the Program Guidelines, this figure must cover all expenses associated with engaging a nurse, including recruitment, training, salary, superannuation, leave loading, professional development, travel and other expenses (computer/phone/car). The nurse's salary is at the discretion of the organisation engaging the nurse, however the Australian College of Mental Health Nurses advocates that nurses who take up a position within the *Mental Health Nurse Incentive Program* should be paid at a rate no less than a clinical nurse specialist (NSW) or state equivalent. As at February 2009, this equates to an hourly rate of \$35.07, or an annual figure of \$69,538.35.

The following sections (6.1, 6.2 and 6.3) give examples of budgets that have been drawn up to support the Mental Health Nurse Incentive Program. Feedback on each of these examples has been sought from various stakeholders, and is included (where available) after each example.

6.1 Financial Model 1 – Developed by Division of General Practice

INCOME		\$
Establishment Grant		10,000
Payments from Medicare @ \$240 / session x 10 sessions / week x 45 weeks per year (allowing for holidays, training leave, etc)		108,000
	Income TOTAL	118,000
COSTS		
Mental Health Nurse @ \$35/hr x 38hrs / week x 52 weeks / year		69,160
On-Costs:		
• Holiday Loading @ 17.5% x 4 weeks		931
• Superannuation @ 9%		6,224
Ancillary Expenses:		
• Clinical supervision (eg \$200 x 22 sessions / year = \$4,400.00)		} 8,220
• Provision of laptop, mobile, car allowance, internet connection		
• Professional development		
• Provision of group therapies – funding for preparation time		
• Health promotion activities of MHN within primary care environment		
• Infrastructure support for the general practice		
Administrative Fees – 20%		33,465
	Cost TOTAL	118,000
<p>Considerations/Assumptions:</p> <ul style="list-style-type: none"> • Figures are based on a full time nurse claiming 2 sessions/day (7 hours), 5 days/week, for 45 weeks out of 52. The calculations will be affected if the nurse cannot claim 2 sessions/day for the 45 weeks. • The income generated needs to cover wages for: 45 weeks normal pay, 4 weeks recreational leave, 2 weeks sick leave and 1 week professional development. • Rural areas receive 25% loading (additional \$26,400) to assist with additional expenses occurred in rural areas. However, nurses working in rural areas may have difficulty providing 2 sessions/day due to travel/time/distance restraints. • The division carries the liability if a GP moves interstate or ceases practicing, effectively cancelling the provider number under which the services were provided. The risk is that Medicare will not honour the sessional payment and the division will not receive payment. It is imperative, irrespective of the model of service delivery, that the agency engaging the nurse is aware of the guidelines and remains on top of any Medicare issues; • MHNIP is a non-profit program 		

6.2 Financial Model 2- Using Queensland Health Pay Rates

INCOME		\$
	Establishment Grant	10,000
	Payments from Medicare @ \$240 / session x 10 sessions / week x 44 weeks per year (allowing for holidays, CPD, sick leave)	105,600
	Income TOTAL	115,600
COSTS		
	Mental Health Nurse @ \$40/hr x 37.5hrs / week x 52 weeks / year (NO4 level Queensland Health)	78,000
	On-Costs:	
	• Superannuation @ 12.5%	9,750
	• Professional development	2,500
	• Other expenses	3,350
	• Management/Infrastructure	12,000
	Cost TOTAL	105,600
	SURPLUS	10,000
<p>Considerations/Assumptions:</p> <ul style="list-style-type: none"> • Figures are based on a full time nurse doing 2 sessions/day (7 hours), 5 days/week, for 44 weeks out of 52. The calculations will be affected if the nurse cannot do 2 sessions/day for the 44 weeks. • The income generated during these 44 weeks needs to cover wages for: 44 weeks normal pay, 4 weeks recreational leave, 2 weeks professional development, 2 weeks sick leave. • Rural areas receive 25% loading (additional \$26,400) – which should assist with additional expenses occurred in rural areas. However, nurses working in rural areas may have difficulty providing 2 sessions/day due to travel/time/distance restraints. • MHNIP is a non-profit program • Program is similar to private work, and does not have public benefits • QUEENSLAND Health allocates approx \$109,000 to fund an N04 position 		

6.2.1 Comments Regarding Financial Model 1 (from General Practice engaged in the Mental Health Nurse Incentive Program)

- The wage paid to the mental health nurse wage needs to match QUEENSLAND Health wage rates, in order to attract nurses. Concern exists over whether an organisation engaged in the *Mental Health Nurse Incentive Program* will remain competitive when QUEENSLAND Health wage rates inevitably increase;
- A General Practice wishing to engage a mental health nurse will need to budget on 44 weeks per year as holiday, sick pay and other absences do not generate any income for general practice.
- General Practice needs to keep in mind that in the initial phases they might have to operate this program on a negative cash flow as payments from Medicare initially may take some time to start.
- Session times only really suit full time nurses, not nurses who are only available to work 5 – 6 hours per day. The system of sessions being based on 3.5 hours really means they can only work one session per day, when in fact they have time to see more patients and complete more work;
- A further expense incurred by many organisations is obtaining the required 'professional indemnity'. This is not costed above.

6.3 Financial Model 3 – Developed by Division of General Practice

Mental Health Nurse Incentive Program (Contractor Model)	
(The 'contractor' example is for one nurse working 5 sessions/week. Adjustments can be made to the figures to allow for more sessions worked and more nurses contracted)	
INCOME	\$
Establishment Grant	10,000
Payments from Medicare @ \$240 / session x 5 sessions / week x 52 weeks per year	62,400
Income TOTAL	72,400
COSTS	
Mental Health Nurse contractor fees \$220 / session x 5 sessions / week x 52 weeks / year. As a contractor, this figure includes: Contractor fee, Mobile phone, Travel, Superannuation, Professional Development, Clinical Supervision; PAYG Instalments	57,200
Division of General Practice administration fee (8.33%)	5,200
Establishment and recruitment costs, including: Mental health nurse recruitment, General Practice recruitment, Marketing of the program, Orientation tools, Resource development	10,000
Cost TOTAL	72,400
<p>Considerations/Assumptions:</p> <ul style="list-style-type: none"> • Under a contractor model, there is no obligation for the Division of General Practice to cover leave entitlements. This is factored into the contractor fee; • As a private contractor, the mental health nurse is responsible for their tax, and can do so through the PAYG instalments system. The nurses are also responsible for applying for an ABN and also registering for GST (if applicable); • The division carries the liability if a GP moves interstate or ceases practicing, effectively cancelling the provider number under which the services were provided. The risk is that Medicare will not honour the sessional payment and the division will not receive payment. It is imperative, irrespective of the model of service delivery, that the agency engaging the nurse is aware of the guidelines and remains on top of any Medicare issues; • The Mental Health Nurse Incentive Program is a not for profit program; • Using the above as a guide, if a Division of General Practice contracts six nurses, who worked a total of 30 sessions / week, the following figures would apply: <ol style="list-style-type: none"> 1. Income generated from sessional payments - \$374,400 (+ \$10,000 establishment) 2. Payments to contractors - \$343,200 3. Payment to Division to cover administration - \$31,200 (+ \$10,000 establishment) 	

7.0 Other Issues to Consider

7.1 Health of the Nation Outcomes Scale (HoNOS)

The Health of the National Outcomes Scale (HoNOS) is used to measure the health and social functioning of people with a severe mental illness. It was developed by the Royal College of Psychiatrists' Research Unit between 1993 and 1996, and now forms part of the United Kingdom minimum dataset for mental health. Mental health nurses working as part of the *Mental Health Nurse Incentive Program* are required to administer the HoNOS for each patient on entry, every 90 days and on exit from the Program. To download a copy of the HoNOS, visit <http://www.gpcare.org/> and click on **Outcome Measures**.

Copyright of the HoNOS is owned by the Royal College of Psychiatrists, however the Australian Government has permission to use the HoNOS, in any format, free of charge under the 'HMSO's Click-Use Licensing Scheme' (see NSW Government Department of Health website for further information: http://www.health.nsw.gov.au/mentalhealth/mh-oat_copyright.asp).

The majority of nurses working as part of the *Mental Health Nurse Incentive Program* will have already received training in the use of the HoNOS, as the scale forms part of the minimum dataset for the Queensland public mental health service, but there may be a handful of nurses working within Queensland, who have come from interstate or overseas, or who have come back into the workforce after some considerable time off, who may need to access some training. Training in the use of the HoNOS is compulsory, as articulated in the Program Guidelines, however access to available courses is proving difficult.

At the time of preparing this document (February 2009), there were a couple of courses in the development phase:

- The Australian College of Mental Health Nurses is working to develop a free online training course that will attract CPE points for nurses. The College will announce if and when this course becomes available. Contact Marilyn Gendek at the College for further information – <http://www.acmhn.org/>;
- The Australian Mental Health Outcomes and Classification Network is also looking to develop an online training course. The website for the network is <http://www.mhnooc.org/amhocn/>, however at time of preparing this document (February 2009), there was no information available regarding the HoNOS training. Contact Marilyn Gendek at the Australian College of mental health nurses for further information – <http://www.acmhn.org/>;
- The Mental Health Coordinating Council has indicated that they can deliver a one-day HoNOS training course. Numbers would be limited to 15-20, and cost would be \$2,500 per course, plus airfare and accommodation for the trainer. Contact Trevor Hobday at the Council for further information – <http://www.mhcc.org.au/home/>.

As a first port of call, contact the Australian College of Mental Health Nurses for information on training courses that might be available in your area. The Australian Government has also advised that organisations should feel free to contact the Department of Health and Ageing in their relevant state/territory for further information.

7.2 Credentialing

From 31 December 2009, eligible organisations must engage the services of a mental health nurse *credentialed* with the Australian College of Mental Health Nurses. Until 31 December, *interim arrangements apply*, and eligible organisations can engage nurses with “current registration who have obtained, or are working towards obtaining, specialist qualifications in mental health, such as a Graduate Diploma in Mental Health Nursing or a Masters in Mental Health Nursing, and three years recent experience in mental health nursing” (See Section 3.6).

The Australian College of Mental Health Nurses provides the following information about credentialing on their website (Visit <http://www.acmhn.org/> then go to **MHN Incentive Program** then **Education and Credentialing**):

“If you are planning to undertake a postgraduate course in mental health nursing for the purposes of credentialing as a specialist mental health nurse, the minimum qualification is a graduate diploma in mental health nursing. Some Master degree courses offer exit points at graduate diploma level and graduate certificate level. A graduate certificate alone is insufficient for the purposes of credentialing.

If you choose an alternative course of study to a graduate diploma in mental health nursing, and wish submit an application for credentialing as a mental health nurse, you will need to put forward a case for equivalence of your qualifications. Please check the guidelines for applications for further information.

Each University conducts its own course based on its own requirements. Therefore, courses vary in their structure and content and it is recommended that the following elements be investigated when you are choosing a course.

The elements below will assist you in identifying a course that is mental health nursing specific. Information about each course should be sought from the relevant University.

- *The title of the course includes the terms “mental health nursing” or “psychiatric nursing”.*
- *The course is provided through the department/school of nursing or nursing and midwifery in the relevant University.*
- *There are units in the course which require you to undertake, and be assessed on clinical nursing practice in a mental health setting. This may be undertaken while you are working in a mental health nursing setting or the units may be specifically related to clinical practice.*
- *At least four of the units of the course are specifically about mental health nursing. Some courses will include generic or core units such as research/evidence based practice, or contemporary nursing.”*

The College also provides a list of courses that may be of interest to nurses looking to undertake postgraduate studies in Mental Health Nursing (www.acmhn.org/files/mhni_courses.pdf). A list of the courses available in Queensland is given below:

Education Provider	Mode	Course Name	Contact details
Griffith University – School of Nursing and Midwifery	Flexible Delivery	Master of Advanced Practice (Mental Health Nursing Major)	Karen Wallen 07 5552 9702 k.wallen@griffith.edu.au <i>See Link 1 below for further information</i>
University of Queensland – Department of Psychiatry	Internal/ External	Graduate Diploma in Mental Health (Mental Health Nursing Major)	07 3163 8564 or 07 3271 8655 r.king1@uq.edu.au or Kams_Pillay@health.Queensland.gov.au <i>See link 2 below for further information</i>
University of Southern Queensland – School of nursing and Midwifery	External	Master of Mental Health Nursing	Prof Don Gorman 1800 640 678 studysci@usq.edu.au or gorman@usq.edu.au <i>See Link 3 below for further information</i>
University of the Sunshine Coast – Faculty of Science, Health & Education	Blended Delivery	Master of Mental Health Nursing	Dr Margaret McAllister Ph: 07 5456 5032 mmcallis@usc.edu.au <i>See link 4 below for further information</i>
James Cook University – School of Nursing Midwifery & Nutrition	External	Graduate Diploma in Forensic Mental Health Master of Forensic Mental Health <i>Please Note: these forensic mental health programs are not offered in 2009. Contact the course coordinator for further information.</i>	Prof Colin Holmes 07 4781 5320 nursing@jcu.edu.au <i>See link 5 below for further information</i>

Links to university/faculty websites:

- http://www17.griffith.edu.au/cis/p_cat/admission.asp?ProgCode=5424&Type=overview
- http://www.uq.edu.au/study/program.html?acad_prog=5126
- <http://www.usq.edu.au/handbook/2009/sci/MMHN.html#programsummary>
- <http://www.usc.edu.au/Students/Handbook/Postgrad/OnCampus/Science/SC720/>
- http://www.jcu.edu.au/future/idc/groups/public/documents/information_about/jcudev_015509.pdf (page 61)

Further information about the College's Credentialing Program, including all applications and forms is available from the College's website. Visit <http://www.acmhn.org/> then **Credentialing**.

7.3 Pay Rates for Mental Health Nurses

The Australian College of Mental Health Nurses (ACMHN) advocates that nurses who take up a position within the *Mental Health Nurse Incentive Program* should be paid at a rate no less than a clinical nurse specialist (NSW) or state equivalent (As at February 2009 – this equates to a minimum hourly rate of \$35.07). Specific arrangements will need to be made with the service that engages or retains the nurse.

The following links provide information on public sector salaries in NSW and QUEENSLAND. Not all states and territories have the same classifications and some may have more than one agreement for different sectors.

- NSW – www.health.nsw.gov.au/nursing/employment/nurse_award_wage_rates_08.asp#a14
- QUEENSLAND – www.health.Queensland.gov.au/nursing/salary.asp

7.4 Professional Development

Credentialed mental health nurses are accustomed to identifying professional development activities that are appropriate and address their needs. These may range from attending conferences and participating in education courses, participating in clinical supervision, through to peer reviewing articles and facilitating education activities for other mental health care professionals. The Australian College of Mental Health Nurses has a range of information available on their website regarding the types of activities that are suitable.

A further activity that many nurses working within the *Mental Health Nurse Incentive Program* are undertaking is the establishment of localised networks, to provide opportunities for peer networking and support. The Australian College of Mental Health Nurses may be aware of networks that are operating in your local area, or alternatively, contact your local Division of General Practice.

7.5 Linkages with other Programs

The Australian Government Department of Health and Ageing expect mental health nurses engaged as part of the *Mental Health Nurse Incentive Program* will work collaboratively with a number of related programs, as part of their role to 'coordinate clinical services for patients with severe mental health disorders' (see Section 3.7.2). The following Australian Government Programs may offer referral pathways for the nurse in support of his/her patient:

- **The Better Access Initiative** – where patients with a mental illness can access Medicare-rebatable psychological services and therapies from psychologists, social workers or occupational therapists, as part of a Mental Health Care Plan developed by their GP. For more information – follow this link: <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/better-access-through-mbs-1>
- **The Better Outcomes Initiative** – where patients with a mental illness can access subsidised psychological services from psychologists, social workers, occupational therapists, mental health nurses and Indigenous Health Workers, as part of a Mental Health Care Plan developed by their GP. GPs are also able to access timely patient management advice from psychiatrists. For more information – follow this link: <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/better-outcomes-mental-health-care-1>
- **The Personal Helpers and Mentors Program** – where people with a severe functional limitation as a result of their mental illness are supported through their recovery. The Personal Helpers and Mentors Program assists by helping people to overcome social isolation and increasing connections to the community. For more information – follow this link: <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/pham-2>
- **The Support for Day to Day Living in the Community Program** – where people with a severe and persistent mental illness are supported to improve their health and quality of life through the provision of structured and socially based activity programs. For more Information – follow this link: <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/support-day-to-day-living-community-1>
- **MAHS (More Allied Health Services)** – where patients in rural and remote areas can access allied health professionals practicing within their area. The types of services delivered as part of the MAHS Program are determined by a local needs assessment, and are managed by the local Division of General Practice. For more information – follow this link: <http://www.health.gov.au/internet/main/publishing.nsf/content/health-pcd-programs-mahs>
- **Mental Health Services in Rural and Remote Areas** – where patients with a mental illness in rural and remote areas can access psychological services and therapies from psychologists, social workers, occupational therapists, mental health nurses and Indigenous Health Workers. The program aims to increase services delivered through a flexible model of care, with medical practitioner oversight, in rural and remote areas including those affected by drought throughout Australia. For more information – follow this link: <http://www.health.gov.au/internet/mentalhealth/publishing.nsf/Content/rural-remote-areas-1>

7.6 Workforce Development

With shortages in the numbers of nurses available to take up the Mental Health Nurse Incentive Program, there has been a slower than expected uptake, and a subsequent reduction in the immediate funding available to support the program. The Australian Government has indicated that, should demand increase, funding levels will be reviewed (see Section 7.7).

As an additional measure, the Government has increased the number of scholarships available to support nurses undertaking postgraduate study in mental health nursing. The following media statement was released on 10th October 2008:

“Mental Health Postgraduate Scholarships Boosted

Applications have opened for 230 new postgraduate scholarships in mental health nursing or clinical psychology for the 2009 academic year. An existing 75 full-time-equivalent scholarships will also be available.

The Rudd Government has boosted funding for the Mental Health Postgraduate Scholarship Scheme by \$35 million to increase the number and value of scholarships.

The new scholarships will assist new and continuing postgraduate students in meeting their accommodation, living and travel costs while at university, with up to 50 of the new scholarships dedicated to students from rural and remote areas.

Eligibility criteria and application forms are available from the Australian Psychological Society (www.psychology.org.au) and the Royal College of Nursing Australia (www.rcna.org.au).”

7.7 Ongoing Funding for the Mental Health Nurse Incentive Program

With the release of the 2008/2009 Federal budget, there was some concern over the future of the Mental Health Nurse Incentive Program, given the reduction in funding. The following statement was released from the Australian Government on 3rd June 2008, allaying these concerns:

“2008-09 Budget Implications for the Mental Health Nurse Incentive Program

There will be no changes to the Mental Health Nurse Incentive Program following the identification of savings under the program in the 2008-09 budget. The savings were identified as a result of lower than expected demand and also scarcity of the required workforce.

The Government expects that the remaining funding will be sufficient to meet future demand for the program, however, should take up increase above what is expected, funding levels will be reviewed.

The government has not reduced eligibility for the program - in fact the government recently announced expanded eligibility for the Mental Health Nurse Incentive Program so that mental health nurses can work flexibly across the public and private sectors.

In addition, \$35 million (over four years) will expand the existing Additional Education Places, Scholarships and Clinical Training in Mental Health initiative to increase the availability and value of postgraduate mental health nurse scholarships and postgraduate psychology scholarships (at \$15,000 per annum). 1,070 scholarships for mental health nurses will be provided of which 105 places will be designated rural and remote scholarships. Funding will also be provided to support the mental health nurse credentialing program.”

Medicare Australia has released a *Mental Health Nurse Incentive Program Update*, which contains up-to-date information regarding the Program. The Update is available from the Australian College of Mental Health Nurses website: http://www.acmhn.org/mhni_update_0901.pdf

7.8 Service Delivery in Regional/Rural/Remote Locations

The Australian Government recognised the additional expense that would likely be incurred in more regional areas of the country, and included a 25% loading for all sessions conducted in these areas (see Section 7.8.1), to compensate for these additional costs. This equates to \$300 per session, or \$132,000 per annum for a full time nurse, based on the nurse conducting sessions for 44 weeks out of 52 (allowing for four (4) weeks annual leave, two (2) weeks sick leave, and two (2) weeks spent attending professional development activities). Despite the loading, some concern has still been expressed from Divisions of General Practice regarding the additional time and expense incurred when working in rural and remote locations. Some nurses are travelling over 300km to see patients, which essentially takes up the most part of the 3.5 hour session. An organisation considering taking on the Program in a regional area needs to be aware of the constraints that exist, in order to make an informed decision. Specific guidance from the Australian Government for your specific situation might be the best option, to ensure that all submitted claims are paid, and not rejected because criteria haven't been met.

In addition, the latest Mental Health Nurse Incentive Program Update, released by Medicare Australia, has included some information regarding what activities constitute a session:

"Three and a half hour sessions consist of two individual services to patients. For example, you may combine two of the following services:

- *face-to-face contact with a patient;*
- *writing clinic notes;*
- *telephone contact with a patient, or where reasonable, a member of the patient's family;*
- *discussing the patient with the treating GP or psychiatrist; and/or*
- *reviewing a patient's health care plan/clinic notes."*

As well as information about travel inclusions:

"Where a nurse is required to travel to conduct a session or perform patient related activities under the Mental Health Nurse Incentive Program, the travel can be included as part of a session. For audit purposes, it is important that you keep a log of all travel, including the date, time and distance traveled. If you travel by taxi, make sure you keep receipts."

It is likely that careful planning and organisation must be undertaken when traveling long distances to visit clients, to ensure that all claims submitted are eligible, and therefore the organisation receives payment for the session.

7.8.1 Australian Standard Geographical Classification Remoteness Postcode List

The full document can be downloaded here:

<http://www.adm.monash.edu.au/scholarships/assets/docs/govt-postcode-list.pdf>, however the Queensland postcodes that have been classified as 'outer regional', 'remote' and 'very remote' are listed below:

Region	Postcode
Outer Regional Australia	4287, 4313, 4373, 4374, 4375, 4376, 4377, 4378, 4380, 4381, 4382, 4383, 4384, 4387, 4388, 4390, 4402, 4407, 4408, 4410, 4411, 4412, 4413, 4415, 4416, 4421, 4455, 4581, 4600, 4601, 4605, 4606, 4608, 4611, 4612, 4613, 4614, 4617, 4620, 4621, 4625, 4626, 4627, 4630, 4659, 4660, 4662, 4671, 4673, 4674, 4676, 4677, 4678, 4694, 4695, 4697, 4699, 4712, 4713, 4715, 4716, 4717, 4718, 4720, 4737, 4738, 4740, 4741, 4744, 4750, 4751, 4753, 4754, 4800, 4801, 4802, 4805, 4806, 4807, 4808, 4809, 4810, 4811, 4812, 4813, 4814, 4815, 4816, 4817, 4818, 4819, 4820, 4849, 4850, 4852, 4854, 4855, 4856, 4857, 4858, 4859, 4860, 4861, 4865, 4868, 4869, 4870, 4871, 4872, 4873, 4878, 4879, 4880, 4882, 4883, 4885, 4886
Remote Australia	3424, 4025, 4183, 4385, 4406, 4417, 4418, 4419, 4420, 4422, 4423, 4424, 4425, 4426, 4427, 4428, 4454, 4461, 4462, 4465, 4470, 4486, 4487, 4494, 4496, 4497, 4498, 4705, 4707, 4709, 4719, 4721, 4722, 4723, 4739, 4742, 4743, 4745, 4746, 4756, 4757, 4798, 4799, 4803, 4804, 4824, 4825
Very Remote Australia	4467, 4468, 4472, 4474, 4475, 4477, 4478, 4479, 4480, 4481, 4482, 4488, 4489, 4490, 4491, 4492, 4493, 4724, 4725, 4726, 4727, 4728, 4730, 4731, 4732, 4733, 4735, 4736, 4821, 4822, 4823, 4828, 4829, 4830, 4874, 4875, 4876, 4890, 4891

7.9 Useful MBS Item Numbers to support the Mental Health Nurse Incentive Program (for GPs, Psychiatrists and Allied Health Professionals)

7.9.1 GP MBS Items

MBS Item	Details	Medicare Fee1	Rebate
2710	Preparation of a GP Mental Health Care Plan ²	\$156.85	75% ³ or 100%
2712	Review of a GP Mental Health Care Plan ²	\$104.55	75% ³ or 100%
2713	Mental Health Consultation ²	\$69.00	100%
2721	Provision of Focussed Psychological Strategies, 30 – 40 mins, in-surgery consultation ²	\$84.00	100%
2723	Provision of Focussed Psychological Strategies, 30 – 40 mins, out-of-surgery consultation ²	\$107.50 ⁴	100%
2725	Provision of Focussed Psychological Strategies, 40+ mins, in-surgery consultation ²	\$120.25	100%
2727	Provision of Focussed Psychological Strategies, 40+ mins, out-of-surgery consultation ²	\$143.75 ⁵	100%
721	Preparation of a GP Management Plan ⁶	\$130.65	75% ⁷ or 100%
723	Coordination of Team Care Arrangements ⁶	\$103.50	75% ⁷ or 100%
725	Review of a GP Management Plan ⁶	\$65.30	75% ⁷ or 100%
727	Coordinate a Review of Team Care Arrangements ⁶	\$65.30	75% ⁷ or 100%
729	Contribution to, or review of, a Multidisciplinary Care Plan prepared by another provider ⁶	\$63.75	100%
731	Contribution to, or review of, a Multidisciplinary Care Plan for a patient in a Residential Aged Care Facility, prepared by the facility ⁶	\$63.75	100%

7.9.2 Psychiatrist MBS Items

MBS Item	Details	Medicare Fee1	Rebate
291	GP Referred Assessment and Management Plan ⁸	\$418.20	85%
293	Review of GP Referred Assessment and Management Plan ⁸	\$261.40	85%
296	Initial Consultation of a new patient ⁸	\$240.45	75% or 85%

7.9.3 Allied Health Provider Items

MBS Item	Details	Medicare Fee1	Rebate
80000	Clinical Psychologist – Provision of psychological assessment and therapy, 30 – 50 mins, in-surgery consultation ⁹	\$92.20	85%
80005	Clinical Psychologist – Provision of psychological assessment and therapy, 30 – 50 mins, out-of-surgery consultation ⁹	\$115.20	85%
80010	Clinical Psychologist – Provision of psychological assessment and therapy, 50+ mins, in-surgery consultation ⁹	\$135.30	85%
80015	Clinical Psychologist – Provision of psychological assessment and therapy, 50+ mins, out-of-surgery consultation ⁹	\$158.30	85%
80020	Clinical Psychologist – Provision of psychological assessment and therapy, 60+ mins, group therapy, 6 – 10 patients ⁹	\$34.35 (each pt)	85%
80100	Psychologist – Provision of Focussed Psychological Strategies, 20 – 50 mins, in-surgery consultation ¹⁰	\$65.30	85%
80105	Psychologist – Provision of Focussed Psychological Strategies, 20 – 50 mins, out-of-surgery consultation ¹⁰	\$88.80	85%
80110	Psychologist – Provision of Focussed Psychological Strategies, 50+ mins, in-surgery consultation ¹⁰	\$92.20	85%

continue...7.9.3 Allied Health Provider Items

80115	Psychologist – Provision of Focussed Psychological Strategies, 50+ mins, out-of-surgery consultation ¹⁰	\$115.75	85%
80120	Psychologist – Provision of Focussed Psychological Strategies, 60+ mins, group therapy, 6 – 10 patients ¹⁰	\$23.50 (each pt)	85%
80125	Occupational Therapist – Provision of Focussed Psychological Strategies, 20 – 50 mins, in-surgery consultation ¹⁰	\$57.55	85%
80130	Occupational Therapist – Provision of Focussed Psychological Strategies, 20 – 50 mins, out-of-surgery consultation ¹⁰	\$81.00	85%
80135	Occupational Therapist – Provision of Focussed Psychological Strategies, 50+ mins, in-surgery consultation ¹⁰	\$81.25	85%
80140	Occupational Therapist – Provision of Focussed Psychological Strategies, 50+ mins, out-of-surgery consultation ¹⁰	\$104.70	85%
80145	Occupational Therapist – Provision of Focussed Psychological Strategies, 60+ mins, group therapy, 6 – 10 patients ¹⁰	\$20.65 (each pt)	85%
80150	Social Worker – Provision of Focussed Psychological Strategies, 20 – 50 mins, in-surgery consultation ¹⁰	\$57.55	85%
80155	Social Worker – Provision of Focussed Psychological Strategies, 20 – 50 mins, out-of-surgery consultation ¹⁰	\$81.00	85%
80160	Social Worker – Provision of Focussed Psychological Strategies, 50+ mins, in-surgery consultation ¹⁰	\$81.25	85%
80165	Social Worker – Provision of Focussed Psychological Strategies, 50+ mins, out-of-surgery consultation ¹⁰	\$104.70	85%
80170	Social Worker – Provision of Focussed Psychological Strategies, 60+ mins, group therapy, 6 – 10 patients ¹⁰	\$20.65 (each pt)	85%

- Please note, these figures were correct at time of preparation of this document (February 2009). Please consult the MBS online for the most up-to-date figures:
<http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/Medicare-Benefits-Schedule-MBS-1>
- See section A43 of MBS Explanatory Notes for further information.

- The GP Mental Health Care Items attract a 100% rebate, except where the patient has been admitted to hospital and the service is provided as an in-patient service. In this case, the rebate is 75%.
- This figure is for a single patient. The fee for item 2723 is the fee for item 2721, plus \$23.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2723 is the fee for item 2721 plus \$1.75 per patient.
- This figure is for a single patient. The fee for item 2727 is the fee for item 2725, plus \$23.50 divided by the number of patients seen, up to a maximum of six patients. For seven or more patients - the fee for item 2727 is the fee for item 2725 plus \$1.75 per patient.
- See section A33 of MBS Explanatory Notes for further information.
- An in-hospital service (with a rebate of 75%) is available to private in-patients who are being discharged from hospital, where the usual GP is providing in-patient care.
- See section A18 of MBS Explanatory Notes for further information.
- See section M6.1 of MBS Explanatory Notes for further information.
- See section M7.1 of MBS Explanatory Notes for further information.

8.0 References

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Mathers C., Vos T. and Stevenson C., (1999) "The burden of disease and injury in Australia", Australian Institute of Health and Welfare, Canberra.

Mental Health Council of Australia (2004) "Access to Health Services by People with Mental Illness", MHCA, Australia.

Queensland Government (2008) "Queensland Government Submission to the Senate Select Committee Inquiry into Mental Health Services in Australia".