Government of South Australia
SA Health

South Australian Rural Medical Engagement Schedule (SARMES)

Version 2016.1

Effective 1 July 2016

Table of Contents

1 Introduction 1:1

Our Values 1:1

2 Guiding Principles and Objectives 2:1

3 Policy and Practice Development 3:1

3.1 Country Clinical Governance Committee 3:1
3.2 Role of the Chief Consultants 3:1
3.3 Role of the Principal Medical Officers 3:2

4 Quality, Safety and Risk Management 4:3

4.1 Clinical Privileges (Credentialling) 4:3
4.2 Admitting Privileges (Scope of Practice in the Health Unit) 4:3
4.3 Quality Improvement and Accreditation 4:4
4.4 Patient Safety, Incidents and Reporting 4:4
4.5 Health Unit to Health Unit Transfer 4:5
4.6 Elective Surgery 4:5
4.7 Immunisation of Health Professionals 4:7
4.8 Medical Records and Documentation 4:8
4.9 Clinical Audits 4:8
4.10 Priority of Treatment 4:9
4.11 Treatment of Relative or Dependant 4:9

5 Relationships and Partnerships 5:1

5.1 Orientation / Induction 5:1
5.2 Consultation 5:1
5.3 Criminal History / Police Checks 5:2
5.4 Confidentiality 5:2
5.5 Occupational Health, Safety & Welfare 5:3
5.6 Conduct 5:4
5.7 Bullying / Discrimination / Harassment 5:5
5.8 SAMSOF Grievance Process 5:5

Appendix 1 – On-call – Quantum and Mix of Services

Appendix 2 – On-call Grant

Schedule 1 – GPs/GPProceduralists

Schedule 2 – International Medical Graduates

Schedule 3 – Specialists

Schedule 4 – Salaried Medical Officers

Schedule 5 – Other Models

Schedule 6 – South Australian Medical Schedule of Fees

1 Introduction

The South Australian Rural Medical Engagement Schedule (SARMES) represents a practical and genuine investment in fostering and supporting relationships between country based Specialist Medical Practitioners and country health services/units.

Furthermore, this Schedule recognises the pivotal role country based medical practitioners play in the provision of health services in country South Australia.

Integral to the success of this Schedule is the process of involving medical practitioners more collaboratively in the provision and planning of services and the care of patients as related to country health services/units.

In addition to its purpose as a tool of engagement, this Schedule details the standard fees, payments and allowances payable to medical practitioners who provide services to patients in health services/units across country South Australia.

Our Mission

The mission of CHSA is to:

- deliver accessible, equitable and high quality health services to country South Australians;
- promote health and well-being amongst country South Australians.

Our Values

Country Health SA operates from a position which values consumers, staff and partners in health and places a premium on accountability, access and equity, safety, empowerment, personal and professional integrity, respect, strength and courage.

2 Guiding Principles and Objectives

The guiding principles and objectives of the South Australian Rural Medical Engagement Schedule (SARMES) are based on:

- mutual agreement and commitment to the value and importance of partnerships and good relationships in the delivery of positive outcomes in health care
- the importance of the relationship between medical practitioners and health service providers as the foundation of effective and efficient health care for country South Australia
- SARMES being the primary tool of engagement between country-based medical practitioners and country public health services/units
- transparency of process, an equitable structure, and consistency in the payment of medical practitioners working in country South Australia
- a mutual obligation to provide accurate and appropriate records relating to fees and payments that meet audit standards
- the provision of clarity and consistency in communicating payments, allowances, fees, expectations and responsibilities and
- the principles of natural justice

3 Policy and Practice Development

The function of Service Design and Quality in the Country Health SA structure covers areas such as program design, services standards, clinical leadership and service delineation. Policy and practice development falls within these functions.

3.1 Country Clinical Governance Committee

Purpose

The purpose of the Country Clinical Governance Committee is to provide a forum where clinical leaders within the South Australian health system share their collective knowledge, provide advice on clinical issues make recommendations on decisions in relation to clinical health planning and clinical governance.

Membership

The membership comprises representation of the following:

- Chief Executive, Country Health SA
- Chief Medical Advisor, Country Health SA
- Chief Medical Officer, Public Health and Clinical Coordination, Department of Health
- Chief Nursing Officer, Department of Health
- Director of Nursing/Midwifery, Country Health SA
- 7 Chief Consultants, Country Health SA
- CEO, Rural Doctors Workforce Agency (RDWA)
- Senior Clinician with Clinical Governance Responsibility, Southern Adelaide Health Service
- Senior Clinician with Clinical Governance Responsibility, Central Northern Adelaide Health Service
- Principal Allied Health Advisor, Country Health SA
- Director, Statewide Retrieval Service
- Executive Director, Safety and Quality, Country Health SA

3.2 Role of the Chief Consultants

- responsible for providing clinical system advice and broad support to rural resident medical practitioners in country South Australia, in their identified area of expertise
- act as a point of contact for clinicians in country regarding system issues, as related to their specialty area, and participate in problem resolution
- participate in the development of policy and procedures that guide clinical practice in country. In addition, the Chief Consultants will work with the Chief Medical Adviser, Country Health SA and other

country health staff related to decision making and policy setting as related to their speciality area

- contribute to the development and implementation of the Country Clinical Governance Plan and
- provide leadership and coordination for the implementation of Country Health SA priorities and action plans within the context of the medical workforce

As at March 2010, the Country Health SA Chief Consultants are;

Dr Sarah Norton	Anaesthetics
Mr Mike Damp	Surgery
Dr Peter Joyner	Emergency
Dr David Rosenthal	Safety & Quality
Dr Steve Holmes	Obstetrics
Dr Mike Beckoff	Mental Health
Dr Nigel Stewart	Services Planning

3.3 Role of the Principal Medical Officers

The Principal Medical Officer provides a clinical perspective on issues and systems within the health unit.

The Principal Medical Officer acts as a principal medical advisor, is a conduit between other medical practitioners and the Executive; advises on clinical policy development and clinical protocols, is involved with the development of service delivery within the health unit and supports students in training.

This role is being reviewed as part of the cluster clinical review due to the implications of the Health Care Act 2010.

3.4 Role of the Director of Medical Services

The Director of Medical Services for each of the country health service cluster grouping is responsible for the development, provision, evaluation and management of the medical services within the health unit.

Each Director of Medical Services is responsible to their cluster Director, but will also work collaboratively with the Chief Medical Advisor, Country Health SA on issues related to clinical practice.

4 Quality, Safety and Risk Management

4.1 Clinical Privileges (Credentialing)

Clinical Privileges determine the Clinical Domain(s) and Competencies (range of procedures) that a medical practitioner is deemed competent to perform (as determined by a process of formal review of his/her qualifications, training, skills and experience, by a group of professional peers) – sometimes termed 'credentials' or 'clinical responsibilities'.

4.2 Admitting Privileges (Scope of Practice in the Health Unit)

Admitting Privileges are authorised by each health unit for a medical practitioner to provide to patients under their primary care those procedures or services, which depend upon the medical practitioner's recommended Clinical Privileges, and the approved Service Level and availability of resources, of the hospital.

4.2.1 Policy Reference:

'Clinical Privileges in SA Country Public Health Services'[1] *and 'Admitting Privileges in SA Country Public Health Services'*[2] *(Country Health SA – May 2006).* Theseare Country Health SA policies,which have been approved by the Country Health SA Board.

These policies are being reviewed to meet requirements under the Health Care Act 2010.

4.2.2 Responsibility of the Health Unit:

- recommend appropriate admitting privileges to the Health Unit Board
- ensure that the medical practitioner has the appropriate medical insurance for the scope of practice at that health unit and
- act as point of contact for the lodgement of clinical privileging applications (recommendations are made by either the Central or Regional Clinical Privileges Advisory Committees)

4.2.3 Responsibility of the Medical Practitioner:

The medical practitioner provides medical services that are:

[1] Clinical Privileges in SA Country Public Health Services (Country Health SA – May 2006)
[2] 'Admitting Privileges in SA Country Public Health Services" (Country Health SA – May 2006)

- within the ambit of his or her clinical privileges current at the time of provision of service
- approved by the Health Unit Board concerned
- consistent with the health unit's service level and current needs and
- provides evidence of ongoing CME, applicable to their area of practice

4.3 Quality Improvement and Accreditation

4.3.1 Policy Reference:

Local health unit Quality Improvement/Accreditation policies and guidelines[3].These policies are developed as per Quality Improvement Programs (e.g. ACHS, EQuIP).

4.3.2 Responsibility of the Health Unit:

- demonstrate that the health unit has successfully informed medical practitioners engaged by the unit (resident and visiting) of all appropriate policies, standards and guidelines that affect medical practice
- ensure that all services provided by and through the health unit are delivered in line with best practice and the relevant policies, standards and guidelines
- ensure the provision of appropriate infrastructure and
- administration and coordination of quality improvement programs and the accreditation process within the health unit, toward the achievement of accreditation

4.3.3 Responsibility of the Medical Practitioner:

Assist the Hospital's Board of Directors to ensure that medical services are delivered effectively by:

- active participation in quality and safety and quality improvement programs of the health unit and
- co-operating and participating in the health unit's accreditation process

4.4 Patient Safety, Incidents and Reporting

4.4.1 Policy Reference:

'Patient Safety Framework'. This is a Department of Health policy, which aims to improve patient safety and the quality of services provided across the public health system.

[3] Quality Improvement /Accreditation policies and guidelines – Available through the Health Unit

4.4.2 Responsibility of the Health Unit:

- implement all policies and procedures related to patient safety, incident and reporting
- conduct and oversee safety activities (including AIMS and Root Cause Analysis) and
- investigate and manage all reports of serious incidents, accidents and near-misses

4.4.3 Responsibility of the Medical Practitioner:

- participate in patient safety activities
- report all serious incidents and accidents immediately (or as soon as reasonably practicable)– to enable ease of reporting, incident forms have been replaced by the ability to contact the SA Incident Management System contact centre on 1800 668 439, for incidents such as medication errors, etc
- Medical Practitioners may also be involved in the reporting of 'sentinel events' to the Department of Health. There are eight national sentinel events:
    1. Procedures involving the wrong patient or body part
    2. Suicide
    3. Retained instruments or other material requiring further surgical procedure
    4. Intravascular gas embolism resulting in death or neurological damage
    5. Haemolytic blood transfusion
    6. Medication error leading to death
    7. Maternal death or serious morbidity associated with labour or delivery
    8. Infant abduction or discharge to the wrong family
- reporting is usually done via the CEO or DON, however, medical practitioners can report sentinel events with 24 hours via the appropriate form, available from the health unit

4.5 Health Unit to Health Unit Transfer

All acute patients requiring observation and/or stabilisation to be transferred from one health unit to another by ambulance should be admitted to their health unit of presentation.

4.6 Elective Surgery

4.6.1 Policy Reference:

Elective surgery and systems at South Australian country public hospitals will be managed in accordance with the *'Department of*

Health – Country Health SA– Elective Surgery Policy[4] and the policy and standards outlined in the *'Department of Health Risk Management Policy and Framework*[5]*.*

4.6.2 Responsibility of the Health Unit:

- identify procedural work which can be undertaken for the next 12 months and associated Fee for Service (FFS) expected expenditure
- provide an elective theatre roster for a period of 12 months (financial year) that is updated no later than the 20th of April each year for the following financial year so that there is a minimum of three months notice of provision of funded lists for resident/visiting providers
- provide resident/visiting providers with appropriate and timely information to enable them to plan their clinical workload and lifestyles appropriately and provide increased transparency to workload
- ensure that all general practitioners participating in on-call rosters will be advised no less than three months in advance of their commitment to the health unit to ensure the respective clinics can then roster GP anaesthetists to the theatre roster and
- advise all visiting specialists by the 20th of April each year of their commitments to the health unit for the following financial year thereby providing a reasonable degree of flexibility to both parties
- provide resident/visiting providers with Health Unit collected Elective Surgery Waiting List information as requested

4.6.3 Responsibility of the Medical Practitioner: provide a predictable, consistent service

- advise the health unit no less than one month in advance of the cancellation of a monthly list or in the case of weekly lists, no less than a fortnight
- provide the health unit with operating lists 10 days in advance to ensure an appropriate mix and supply of consumables and instrumentation is available and
- ensure that where possible patients will have their surgery in the local health unit instead of being added to a public metropolitan waiting list unless there are medical reasons that contraindicate this strategy
- work with Country Health SA in providing timely and accurate Elective Surgery Waiting List information to the necessary Health

[4]Department of Health – Country Health SA – Elective Surgery Policy – Available through the Health Unit

[5]Department of Health Risk Management Policy and Framework – Contact Department of Health, Workforce Services Unit – Ph (08) 8226 6552

Unit in order that a complete understanding of actual elective surgery waiting times can be obtained

4.7 Immunisation of Health Professionals

4.7.1 Policy Reference:

'Immunisation Guidelines for Health Care Workers in South Australia'[6] *(January 2006).*

Note – These Guidelines are voluntary and will remain voluntary during 2010– this information is provided to ensure that all parties have reasonable notice of a change in policy.

Further development on this policy is currently occurring.

4.7.2 Responsibility of the Health Unit:

- to implement the 'Immunisation Guidelines for Health Care Workers in South Australia'
- Medical Practitioners who are attached to and provide services for country health units will be provided free vaccinations similar to those offered to health unit employees.

4.7.3 Responsibility of the Medical Practitioner:

Medical practitioners should strongly consider:

- taking reasonable steps to be aware of their own infectious disease and vaccination status to minimise the risk of transmitting infectious diseases to patients or other staff
- being vaccinated against vaccine preventable diseases such as Polio, Diphtheria / Tetanus, Hepatitis B, Influenza and Pertussis (see Immunisation Guidelines 'Vaccination recommendations' for further information), and especially those persons working in high-risk areas e.g. emergency, obstetrics and surgery and
- complying with the health unit's screening, education and vaccination program, including the 'Immunisation Guidelines for Health Care Workers in South Australia'

[6] Immunisation Guidelines for Health Care Workers in South Australia – www.dh.sa.gov.au/pehs/immunisation-index.htm

4.8 Medical Records and Documentation

4.8.1 Policy Reference:

'South Australian Medical Record Documentation and Data Capture Standards'[7]*.* These are Department of Health standards, which are applicable across the public health system.

4.8.2 Responsibility of the Health Unit:

- ensure the creation, storage and maintenance of patient medical records in accordance with best practice standards, guidelines and policies

4.8.3 Responsibility of the Medical Practitioner:

- maintain accurate contemporaneous and legible patient medical records in accordance with best practice standards, the requirements of the health unit and the 'South Australian Medical Record Documentation and Data Capture Standards' and other relevant guidelines and standards and
- ensure that medical records are not removed from the health unit, except upon prior authorisation from the hospital executive or delegate

4.9 Clinical Audits

4.9.1 Policy Reference:

Clinical audits are conducted via health units as required by Country Health SA.

4.9.2 Statewide Audits:

- South Australian Audit of Perioperative Mortality (SAAPM)
- Pregnancy Outcome
- Cancer Registry
- Perinatal Mortality

4.9.3 Responsibility of the Health Unit:

- oversee, encourage and coordinate input to clinical audits as necessary in a 'no blame' environment and
- participate in clinical audits as required

4.9.4 Responsibility of the Medical Practitioner:

- participate in clinical audits as conducted by Country Health SA via health units, e.g. which may include peer review of de-identified medical records

[7] South Australian Medical Record Documentation and Data Capture Standards – Only available in hard copy – Available through the Health Unit

4.10 Priority of Treatment

With respect to priority for treating patients, clinical need is to be the primary factor to be considered. Where patients' clinical needs are not significantly different, the patient who had been waiting longest for medical services shall be given priority.

4.11 Treatment of Relative or Dependant

Normally, it is not expected that a medical practitioner would treat one of their relatives or dependants as an admitted patient. Under Commonwealth Medicare Benefits Schedule these would not be able to be charged to Medicare in the private sector. For the rare occasion for an urgent acute illness requiring admission, where the medical practitioner is on-call and no other medical practitioner is available, then an initial payment may be made. However, it is expected that the medical practitioner will be transferring the care of the patient to another medical practitioner as soon as practicable, in line with ethical practice.

5 Relationships and Partnerships

5.1 Orientation / Induction

5.1.1 Policy References:

'Corporate Induction Policy'. This is a Department of Health policy, which is applicable across the public health system.

Local health unit '*Orientation / Induction Policy'* – adapted from the Department of Health's Corporate Induction Policy.

'Rural Doctors Workforce Agency Orientation Manual'

'Code of Professional Conduct'- Medical Board of SA

5.1.2 Responsibility of the Health Unit:

- provide a formal orientation / induction to all new medical practitioners, as service providers to the health unit, on commencement
- familiarise all new medical practitioners with the existence and location of all relevant documents including values, goals, strategic directions, plans, policies, guidelines, procedures, by-laws and protocols relevant to their practice in the health unit/service and
- familiarise all new medical practitioners with the work environment including organisational cultures, work relationships, structures, systems and resources

5.1.3 Responsibility of the Medical Practitioner:

- actively engage in the health unit orientation / induction process with the view to integrate into the new work environment quickly and effectively
- seek clarification or advice if required and
- familiarise themselves with the health unit, its operations, services, staff, relevant policies, guidelines, procedures, by-laws and protocols

5.2 Consultation

In support of consultation and a planned approach to service provision, health unit representatives should meet with medical practitioner(s)on a regular basis, documenting these meetings. Furthermore,

- where a hospital proposes to implement changes in program, organisation, structure or technology that are likely to affect medical practitioners, the health unit shall consult the medical practitioners during the planning process as far as possible, and

- in circumstances where a health unit or medical practitioner plans to cease an existing service there shall be a period of notice of not less than three months and wherever possible 12 calendar months

5.3 Criminal History / Police Checks

5.3.1 Policy Reference:

'Interim Whole of Health Criminal History Screening Minimum Standard' [8] *(Department of Health – November 2005).* This policy is based on *The Children's Protection (Miscellaneous) Amendment Act, 2005*.

Consistent with the '*Interim Whole of Health Criminal History Screening Minimum Standard*', and or the health unit's criminal history / police check policy, the medical practitioner, as service provider, may be required to undergo a criminal history check, prior to the provision of services.

Note–This [minimum standard, mandatory] policy is under final development. Currently, new employees are checked via these standards and the interim standards applicable to all staff and contractors are expected to be implemented in the near future.

"Offender History Checking' Country Health SA – Workforce Services December 2007

5.4 Confidentiality

5.4.1 Policy References:

Code of Ethics, AMA (2004)[9]

Code of Conduct for South Australian Public Sector Employees (March 2005)[10]. This is a State Government, Public Sector wide policy.

South Australian Medical Record Documentation and Data Capture Standards, Department of Health (2000)[11]

Freedom of Information Act, 1991

Code of Fair Information Practice

[8] Interim Whole of Health Criminal History Screening Standard – Available through the Health Unit

[9] Code of Ethics, AMA(2004) – www.amasa.org.au

[10] Code of Conduct for South Australian Public Sector Employees –www.cpe.sa.gov.au

[11] South Australian Medical Record Documentation and Data Capture Standards – Only available in hard copy – Available through the Health Unit

Privacy Act, 1988

Code of Professional Conduct, Medical Board of South Australia[12]

5.4.2 Responsibility of the Health Unit:

- oversee and administer and maintain the overall safety, storage and quality of health unit patient medical records and
- maintain the confidentiality of patient's personal health information in accordance with privacy requirements, relevant legislation, organisational guidelines and as otherwise lawfully permitted and required

5.4.3 Responsibility of the Medical Practitioner:

- maintain the confidentiality of patient's personal health information in accordance with privacy requirements, relevant legislation, organisational guidelines and as otherwise lawfully permitted and required
- ensure security of storage, access and utilisation of patient information and
- ensure that the medical record is not removed from the health unit unless prior authorisation is given from the hospital executive or delegate

5.5 Occupational Health, Safety& Welfare

5.5.1 Policy References:

'Department of Health – Workforce Health and Safety'[13]. This is a Department of Health policy, which is applicable across the public health system and is in accordance with the legislation below.

Occupational Health Safety & Welfare Act, 1986[14]

Occupational Health, Safety and Welfare (Penalties) Amendment Act 2007

5.5.2 Responsibility of the Health Unit:

To meet its duty of care responsibilities, the health unit will ensure a safe and healthy work environment to eliminate risks to the health, safety and welfare of persons in the workplace by:

- securing and promoting the health, safety and welfare of people at work
- promoting the adoption of safe work practices

[12] Code of Professional Conduct, Medical Board of South Australia – www.medicalboardsa.asn.au
[13] Department of Health, Workforce Health and Safety Unit – Ph(08) 8226 6945

[14]Occupational Health, Safety and Welfare Act, 1986 – www.austlii.edu.au

- protecting people against workplace health and safety risks
- identifying risks and developing measures to eliminate those risks and
- ensuring that all persons entering the health unit comply with Occupational Health, Safety and Welfare legislation and associated health unit policies, guidelines, procedures, by-laws and protocols

5.5.3 Responsibility of the Medical Practitioner:

- to make themselves aware of and adhere to all relevant policies, guidelines, procedures, by-laws and protocols used by the health unit including those related to Occupational Health, Safety & Welfare
- support the promotion of safe work practices and
- identify and report risks in conjunction with health unit representatives

5.6 Conduct

5.6.1 Policy References:

Code of Conduct for South Australian Public Sector Employees (March 2005)[15]*.*This is a State Government, Public Sector wide policy.

Code of Ethics, AMA (2004)[16]

Code of Professional Conduct, Medical Board of South Australia[17]

5.6.2 Responsibility of the Health Unit:

- act professionally at all times and treat the medical practitioner and their staff with respect and courtesy
- approach health care as a collaboration between multiple players and
- act honestly in all dealings with the medical practitioner and practice staff

5.6.3 Responsibility of the Medical Practitioner:

- act professionally and treat all health unit staff, members of the public and colleagues with respect and courtesy
- approach health care as a collaboration between multiple players
- act honestly when performing your duties and
- to adhere to all health unit policies, procedures and protocols

[15]Code of Conduct for South Australian Public Sector Employees – www.cpe.sa.gov.au

[16]Code of Ethics, AMA (2004) –www.amasa.org.au

[17] Code of Professional Conduct, Medical Board of South Australia – www.medicalboardsa.asn.au

5.7 Bullying / Discrimination / Harassment

5.7.1 Policy References:

'Bullying, Discrimination and Harassment Policy'[18]*.*This is a Department of Health policy, which is applicable across the public health system and was developed in accordance with the legislation below.

Equal Opportunity Act, 1984[19]

5.7.2 Responsibility of the Health Unit:

- ensure a safe and healthy work environment and to eliminate risks to the health, safety and welfare of persons in the workplace
- ensure that the health unit is free of discrimination as far as reasonably possible, for the benefit of health unit staff, independent contractors, volunteers, visitors, patients, members of the public and colleagues as per policy, equal opportunity or other anti-discrimination legislation and
- conduct and investigate all claims of bullying, discrimination and/or harassment in the workplace

5.7.3 Responsibility of the Medical Practitioner:

- refrain from engaging in bullying or other forms of harassment, including sexual harassment
- abide by the relevant legislation and related health unit policies/procedures regarding bullying, discrimination and harassment and
- refrain from discriminating directly or indirectly in the treatment of health unit staff, patients, members of the public, visitors and colleagues on any grounds covered by health unit policy, equal opportunity or other anti-discrimination legislation

5.8 SAMSOF Grievance Process

5.8.1 Policy:

The following process outlines the grievance process where there is dispute about interpretation of individual items under the current South Australian Medical Schedule of Fees (SAMSOF) schedule between a medical practitioner and health unit.

[18]Bullying, Discrimination and Harassment Policy – Contact Department of Health, Workforce Services Unit – Ph (08) 8226 6552

[19] Equal Opportunity Act, 1984 – www.austlii.edu.au

The appeal process excludes negotiation of contracts outside of SAMSOF or issues relating to changes in the SAMSOF fee structure for example, increase in funding per item or inclusion of additional items.

5.8.2 Process:

The health unit CEO or delegate in conjunction with the Principal Medical Officer (PMO) (where available):

- will in the first instance attempt to resolve the dispute internally with the medical practitioner
- written response will occur within 10 working days to the medical practitioner and
- if resolution cannot be achieved either the health unit or medical practitioner have the right to refer the matter to the Executive Director (ED), Health Services and notify the other party of the same

The Executive Director, Health Services or delegate in conjunction with the health unit and PMO (where available):

- will attempt to resolve the matter in consultation with the medical practitioner
- written response will occur within 10 working days to the medical practitioner and
- where resolution cannot be achieved either the ED, Health Services or medical practitioner has the right to formally advise Country Health SA of the matter in dispute; and notify the other party of the same

The Chief Medical Advisor, Country Health SA upon receiving notification of the dispute:

- will refer the matter to a sub-committee of the Central Clinical Privileges Advisory Committee for recommendation
- the sub-committee will meet as required at the end of the monthly Central Clinical Privileges Advisory Committee meeting
- the sub-committee will make a recommendation on the matter in dispute which will be referred to the Chief Executive, Country Health SA or delegate for a determination
- the outcome will be communicated to the health unit, Executive Director, Health Services and medical practitioner

5.8.3 Membership of the sub-committee will include:

- two resident country medical practitioners, who are members of the Central Clinical Privileges Advisory Committee
- Chief Medical Advisor, Country Health SA

- Executive Director, Finance & Infrastructure, Country Health SA

Notwithstanding the existence of a dispute, each party must continue to perform its obligations under the current agreement, and/or unless prevented by the nature of the dispute, the parties will continue to perform under the existing agreement while attempts are made to resolve the dispute.

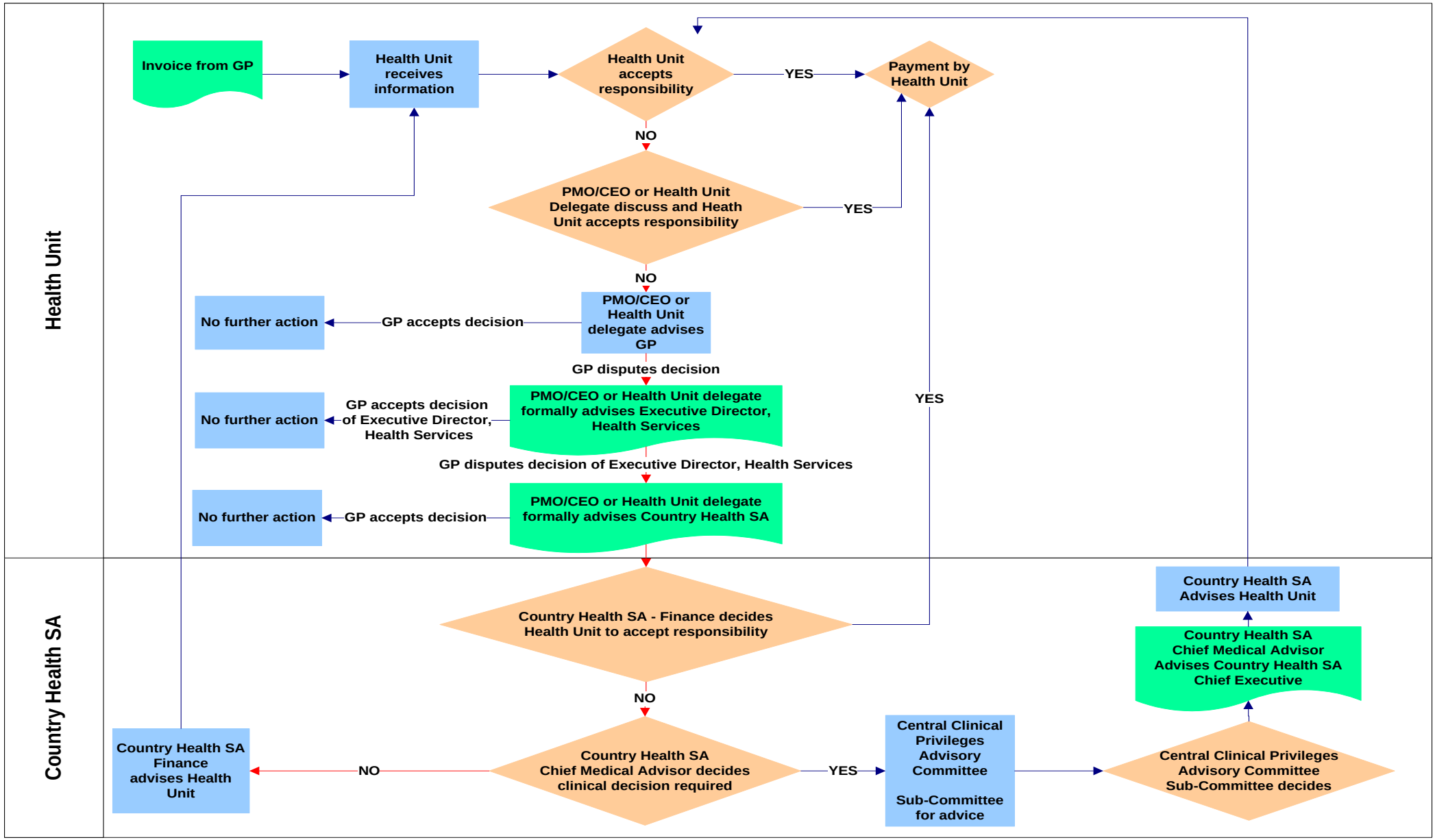
In circumstances where the dispute relates to payment, the medical practitioner is requested to continue to perform obligations under the current agreement and the health unit will continue to pay the medical practitioner any undisputed amounts.

The parties agree to use reasonable efforts to resolve the dispute by negotiating any problem that arises between them under this agreement. Neither party will resort to legal proceedings, or terminate this agreement, until all steps in this grievance process have been exhausted, except if it is necessary to seek an urgent interim determination.

Note–A flowchart describing this process follows.

5.8.4 Expected Outcomes:

- that the dispute between the health unit and medical practitioner with regard to interpretation of individual items under the current SAMSOF agreement is resolved
- all parties involved in the dispute are informed of the resolution and outcome
- any resolution achieved at either the health unit CEO and/or Executive Director, Health Services level is communicated to Country Health SA


Health Unit
Country Health SA
Invoice from GP
Health Unit receives information
Health Unit accepts responsibility
YES
Payment by Health Unit
NO
PMO/CEO or Health Unit Delegate discuss and Heath Unit accepts responsibility
YES
NO
No further action
GP accepts decision
PMO/CEO or Health Unit delegate advises GP
GP disputes decision
No further action
GP accepts decision of Executive Director, Health Services
PMO/CEO or Health Unit delegate formally advises Executive Director, Health Services
YES
GP disputes decision of Executive Director, Health Services
No further action
GP accepts decision
PMO/CEO or Health Unit delegate formally advises Country Health SA
Country Health SA - Finance decides Health Unit to accept responsibility
Country Health SA Advises Health Unit
Country Health SA Chief Medical Advisor Advises Country Health SA Chief Executive
NO
Country Health SA Finance advises Health Unit
NO
Country Health SA Chief Medical Advisor decides clinical decision required
YES
Central Clinical Privileges Advisory Committee
Sub-Committee for advice
Central Clinical Privileges Advisory Committee Sub-Committee decides

Appendix 1– On-call – Quantum and Mix of Services

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Appendix 2–On-call Grant

There are a range of locations identified who provide 24/7 Accident and Emergency cover but do not access a public hospital for their after hours care.

1. In recognition of their work, Country Health SA will pay a grant per registered provider and an annual allocation of $3,000 for practices to supplement the cost to support emergency service (e.g. defibrillator). This grant is capped at $65,000 per location inclusive.
2. The location and providers will be scheduled and published in SAMSOF. The requirement for this service will be reviewed annually by each region and ratified by Country Health SA.
3. This service will require the provider to physically attend on an after hours basis at their practice or the private hospital they service.
4. These payments are made in addition to the Commonwealth funded Practice Incentives Payments which also recognise after hours effort by accredited general practitioners.
5. The general practitioner/practice must maintain a record of accident and emergency calls and consultations made between 6pm and 8am on week days and on weekends, and supply this information to the Region on a monthly basis.
6. The general practitioners who are in towns where there is an on-call roster for the provision of an Accident and Emergency service to a public health unit would not be eligible for this arrangement.

Number of general practitioners in a Practice	Annual on-call payment for each general practitioners providing service	Annual equipment payment per practice
1	$12,000	$3,000
2	$10,500	$3,000
3	$9,000	$3,000
4 or more	$7,500	$3,000

This grant is applicable to the following locations:

- Ardrossan
- Robe

SCHEDULE 1 – GPs/GP PROCEDURALISTS

PLEASE NOTE THAT THIS PAGE IS NO LONGER APPLICABLE FOR GPs AND GP PROCEDURALISTS AND THEY SHOULD REFER TO THE SOUTH AUSTRALIAN RURAL MEDICAL FEE AGREEMENT

1 Payments

1.1 Fee For Service and Billing

1.1.1 the hospital shall remunerate the medical practitioner in accordance with the terms of the South Australian Medical Schedule of Fees (SAMSOF), and Rural Health Enhancement Package (RHEP) where applicable

1.1.2 the payment of invoices shall be made via Electronic Funds Transfer (EFT) in most instances

1.1.3 the medical provisioner shall submit all Fee For Service (FFS) claims within six months of the date of service provision

1.1.4 the medical practitioner shall advise the health unit of the medical practitioner's Australian Business Number (ABN) and quote the ABN on all claims for payment

1.1.5 where the medical practitioner provides medical services as an individual, the medical practitioner's individual ABN must be quoted. Alternatively if the medical services are provided by a partnership, trust or company the ABN of the partnership, trust or company must be quoted

1.1.6 the medical practitioner shall immediately advise the health unit of any changes to the ABN details

1.1.7 based on current advice from the Australian Taxation Office, the supply of medical services, in accordance with this agreement, by the medical practitioner to the health unit is a taxable supply. If the medical practitioner is registered for the Goods and Services Tax (GST) and:

1.1.7.1 if the health unit calculates the amount payable for services rendered by the medical practitioner, the medical practitioner shall enter into a Recipient Created Tax Invoice (RCTI) Agreement with the health unit on an annual basis, or

1.1.7.2 if the medical practitioner calculates the amount payable by the health unit, the medical practitioner shall provide the health unit with a valid tax invoice requesting payment. Should the medical practitioner cease to be registered for

GST purposes, or become aware of any reason why the GST registration may be cancelled, the medical practitioner shall advise the health unit.

1.1.8 If the contract of a medical practitioner is terminated, the health unit shall thereupon pay all fees to which the medical practitioner is then entitled to within one calendar month of:

1.1.8.1 receipt of a valid tax invoice detailing the medical services rendered, where the medical practitioner calculates the amount payable; or

1.1.8.2 the health unit generating a Recipient Created Tax Invoice (RCTI) where the health unit calculates the amount payable

1.1.9 If the Australian Taxation Office changes its advice on the tax treatment of medical services provided under these arrangements, this document will be amended accordingly.

1.1.10 Where the paying entity is required by virtue of the Superannuation Guarantee Administration Act (SGAA) to provide a minimum level of superannuation support on behalf of the medical practitioner into a complying superannuation fund, then the Fee for Service amounts due under this agreement are deemed to be inclusive of the minimum superannuation support calculated in accordance with Australian Taxation Office advice. The Fee for Service payment paid to the medical practitioner is to be net of the minimum superannuation support. The minimum superannuation support will be paid into the medical practitioner's nominated complying Superannuation Fund in accordance of the requirements of the SGAA.

Superannuation contributions made under an *effective salary sacrifice agreement*, as defined in the Australian Taxation Office ruling SGD2006/2, are not assessable income to the deemed employee. Thus doctors will not be subject to income tax on their sacrificed payments. Information regarding salary sacrifice agreements is available from the health unit.

1.1.11 FFS accounts should contain the following information to enable health unit staff to accurately check against the patient/client medical record.

Accounts can only be paid if the relevant documentation exists in the patient/client medical record.

Accounts should be itemised per patient and contain:

- the patient/client name (not their nickname or abbreviated version)
- patient/client status (i.e. public, compensable, veteran etc.)
- their Medicare or DVA number

- service item number (from the SAMSOF)
- date of service
- time the service was initiated and either the duration of the service or the time the service ended
- whether or not the service is a ward round
- the medical practitioner's name and provider number
- the relevant cost for the service and
- the GST amount clearly identified

For 'on-call' charges the amount can be charged as a lump sum or daily but must be accompanied by a breakdown of the charges including a roster showing the date of attendance, the number of days at each charge and if one day is shared by two or more medical practitioners the percentage of payment for each medical practitioner.

Because of the inpatient/outpatient interface and the normal/after hours interface the duration of a service is important as the medical practitioner may be entitled to after-hours fees in instances where they are claiming only normal hours.

It is preferable for RHEP and DVA acquittal reporting purposes that one account for a complete month is submitted within 14 days of the end of that month to be fully remitted in that month.

1.2 The 'South Australian Medical Schedule of Fees – Schedule 6'

The treatment fees payable by a hospital shall be known as the 'South Australian Medical Schedule of Fees' (SAMSOF), Schedule 6 of the 'South Australian Rural Medical Engagement Schedule' (SARMES). SARMES2011, Schedule 6, will be the Commonwealth Medicare Benefits Schedule (CMBS) fee as at 1 November 2010, adjusted by a factor of 7.1%. SAMSOF is updated annually on 1 January to take into account the CMBS issued on the previous 1 November. The Schedule is also available from the Country Health SA website atwww.countryhealthsa.sa.gov.au/Default.aspx?tabid=34.

SAMSOF is not updated for supplemental CMBS updates that may occur at any time, most notably in May. As health unit's Fee for Service systems do not recognise new item numbers, an existing SAMSOF item number of similar description and value should be used instead, pending the inclusion of the new item numbers in the next edition of SAMSOF.

1.3 Hospital Patients

With respect to any patient who elects to be a public inpatient, the medical practitioner shall not raise an account with the patient.

1.4 Private Patients

With respect to any patient who elects to be a private inpatient, the medical practitioner shall charge at the rate judged by the practitioner to be appropriate to the service, subject to informing the patient of the intended fee.

There is a standard *Patient Election* form. The *Patient Election* form allows the patient to be treated as a private or public patient.

1.5 Outpatient/Inpatient Interface

In South Australian country hospitals, (with the exception of Mount Gambier, and, "After-Hours" at Port Augusta, Port Pirie, and Whyalla health units) outpatient and emergency services are provided under the Medicare system, i.e. the patient is charged by the medical practitioner and seeks reimbursement from Medicare.

When a patient is seen in the health unit emergency area and then admitted for treatment as a public inpatient, billing will be as follows:

The critical fact is when the decision to admit is made:

1.5.1 if the majority of the consultation time is before this decision - the patient should be charged for the consultation

1.5.2 if the majority of the consultation time is after this decision - the health unit should be charged for the consultation

1.5.3 where additional (non consultative items) are charged it should be clear whether these services were rendered before or after the decision to admit

1.5.4 correct documentation of when the medical practitioner sees the patient and when the medical practitioner decides on admission is required and

1.5.5 failure to provide correct documentation as above will lead to non payment by the health unit for services rendered, with the medical practitioner required to bill the patient as a private patient for all services associated with the admission process

1.5.6 Medical practitioners should also be advised, when requested, they have an obligation to attend the hospital/health service for serious emergency presentations. This obligation also exists whether or not the presentation is in their area of expertise. This would include attendance at triage 1, 2, and many triage 3 patients who present to the hospital/health service, and includes patients who present with surgical, medical or obstetric concerns.

1.6 Intravenous Therapy

1.6.1 Intravenous therapy (other than that associated with an anaesthetic or chemotherapy requiring intra-venous administration) shall have

an item number (*SAMSOFIVT*) in SAMSOF and will attract a payment of $19.85. This item only applies where the IV insertion is performed by the medical practitioner and noted as such in the medical records. This payment does not attract benefits under the RHEP.

1.6.2 Chemotherapy should be charged and paid in accordance with the following formula:

Initial Treatment:	Level B Consult + Chemotherapy Fee
Subsequent Treatments: (same course)	Chemotherapy Fee Only

Payment of an SAMSOFIVT fee is not appropriate.

1.7 Emergency Care

1.7.1 Where a medical practitioner is required to return to a hospital in a situation where the patient is in imminent danger of death, requiring the medical practitioners' undivided attention for continuous life-saving emergency treatment, the following criteria and fee structure has been determined:

- Emergency item numbers 160-164 (Prolonged Professional Attendance) may only apply to a service on a patient in Triage Category 1 and 2, where required for more than one hour.
- A patient requiring treatment for whom the emergency number be paid would need to have a triage score of 1 or 2 as well as meeting the requirement of the constant presence of a medical practitioner to be maintained.

ATSCategory	Response	Description of Category	Clinical Descriptors (indicative only)
Category 1	Immediate simultaneous assessment and treatment	Immediately Life-Threatening Conditions that are threats to life (or imminent risk of deterioration) and require immediate aggressive intervention.	Cardiac arrest Respiratory arrest Immediate risk to airway - impending arrest Respiratory rate <10/min Extreme respiratory distress BP< 80 (adult) or severely shocked child/infant Unresponsive or responds to pain only (GCS< 9) Ongoing/prolonged seizure IV overdose and unresponsive or hypoventilation Severe behavioural disorder with immediate threat of dangerous violence
Category 2	Assessment and treatment within 10 minutes (assessment and treatment often simultaneous)	Imminently life-threatening The patient's condition is serious enough or deteriorating so rapidly that there is the potential of threat to life, or organ system failure, if not treated within ten minutes of arrival Or Important time-critical treatment The potential for time-critical treatment (e.g. thrombolysis, antidote) to make a significant effect on clinical outcome depends on treatment commencing within a few minutes of the patient's arrival in the ED Or Very severe pain Humane practice mandates the relief of very severe pain or distress within 10 minutes	Airway risk - severe stridor or drooling with distress Severe respiratory distress Circulatory compromise • Clammy or mottled skin, poor perfusion • HR<50 or >150 (adult) • Hypotension with haemodynamic effects • Severe blood loss Chest pain of likely cardiac nature Very severe pain - any cause BSL < 2 mmol/l Drowsy, decreased responsiveness any cause (GCS< 13) Acute hemiparesis/dysphasia Fever with signs of lethargy (any age) Acid or alkali splash to eye - requiring irrigation Major multi trauma (requiring rapid organised team response) Severe localised trauma - major fracture, amputation High-risk history: • Significant sedative or other toxic ingestion • Significant/dangerous envenomation • Severe pain suggesting PE, AAA or ectopic pregnancy Behavioural/Psychiatric: • violent or aggressive • immediate threat to self or others • requires or has required restraint • severe agitation or aggression

1.7.2 Obstetric Emergency Antenatal Consultation

1.7.2.1 Important time-critical treatment

Assessment and treatment of a woman in threatened premature labour requiring consultation with tertiary neonatal and maternity hospital. Treatment may involve tocolysis and transfer to tertiary centre.

1.7.2.2 Imminently life-threatening

Assessment of a pregnant woman with significant signs of pre-eclampsia requiring urgent assessment and investigation of hypertension and treatment with hypotensive medication and consultation with tertiary centre regarding further management, transfer, retrieval etc.

1.7.2.3 Antenatal woman presenting for management of moderate or more blood loss in pregnancy requiring urgent CTG assessment, intravenous resuscitation, and in consultation with tertiary neonatal centre, transfer, retrieval etc;

1.7.2.4 less than one hour –item SAMSOF50;

1.7.2.5 greater than one hour – refer to description in CMBS (Nov 2010), Section A.15 for item numbers 160-164 inclusive. The payment rates will be item SAMSOF 160-164 (which equates to CMBS items 160-164 plus a 50% loading);

1.7.2.6 if the emergency care is initiated after hours, the 'After Hour Payment Rules' will apply (see clause1.11);

1.7.2.7 any other relevant procedural fees (inclusive of RHEP) are payable until the emergency care ceases and/or the patient is transferred to another centre.

The following table represents the structure for payments:

Special Note: Items160-164 represents the SAMSOF payments which includes a 50% loading.

	Mon – Fri 0700 – 1800 **Sat 0700– 1200**	**Mon – Fri 1800 to 2300** **Sat 1200 to 2300** **Sun & PH 0700 to 2300**	**Mon – Fri 2300 to 0700** **Sat 2300 to 0700** **Sun & PH 2300 to 0700**
Less than 1 hr	Item SAMSOF 50	Item SAMSOF 50 + Item 597	Item SAMSOF50 + (Item 597x1.5)
Less than 2 hrs	Item SAMSOF 160	Item SAMSOF 160+ Item 597	Item SAMSOF 160 + (Item 597 x 1.5)
Less than 3 hrs	Item SAMSOF 161	Item SAMSOF 161 + Item 597	Item SAMSOF 161 + (Item 597 x 1.5)
Less than 4 hrs	Item SAMSOF 162	Item SAMSOF 162 + Item 597	Item SAMSOF 162 + (Item 597 x 1.5)
Less than 5 hrs	Item SAMSOF 163	Item SAMSOF 163 + Item 597	Item SAMSOF 163 + (Item 597 x 1.5)
5 or more hrs	Item SAMSOF 164	Item SAMSOF 164 + Item 597	Item SAMSOF 164 + (Item 597 x 1.5)

1.7.3 where a medical practitioner is required to attend a hospital to provide emergency care to more than one patient, and they require continual monitoring and treatment prior to transfer, or specialist intervention, and the treatment prevents the medical practitioner from leaving the hospital, the following payments will apply for each patient:

- the payment shall be item SAMSOF50 for the initial two hours, and then each subsequent two hour segment, or part thereof
- if the emergency care is initiated after hours, the 'After Hour Payment Rules' will apply (see clause 1.11)
- any other relevant procedural fees (inclusive of RHEP where applicable) are payable until the emergency care ceases and/or the patient is transferred to another centre

1.8 Other Medical Practitioners

"Other Medical Practitioners" (as defined in the CMBS) shall be paid at the *Vocational Registered* rate for public inpatient care.

1.9 Surgical Procedural Rates

Surgical procedural rates that have differential payments for specialist and non specialist medical practitioner shall all be paid at the specialist rate (the fees shown in SAMSOF reflect this point).

1.10 Scope Procedural Rates

For the purposes of payments for colonoscopy, endoscopy and oesophagoscopy services approved by the hospital/health service for public funding, the scope Proceduralist and Anaesthetist will be able to access the current 'inpatient' MBS item numbers whether the procedure is performed as an inpatient or outpatient.

1.11 After Hours Attendances and Payments

1.11.1 Definitions

After hours shall be defined as being:

1.11.1.1 Monday – Friday from 18:00 hrs and before 07:00 hrs
Saturdays – before 07:00 hrs and from 12:00 hrs
Sundays and Public Holidays – all day/night.

1.11.1.2 Eligibility for claiming after hour payments (item 597) – refer to CMBS (Nov 2007), Section A.10item 599 is not relevant for the purpose of SAMSOF2011.

1.11.1.3 Descriptions of Level A, B, C, D – refer to CMBS (Nov 2010), Section A.5.

1.11.1.4 Where Christmas Day or New Years Day falls on a weekend, both the public holiday and the Monday that the public holiday is observed are deemed as Public Holidays for the purposes of After Hours.

1.11.2 General Practice Payments

Payment for all after hours inpatient consultations (inclusive of obstetric patients unrelated to confinement and postnatal care) that is not considered part of 'normal after care' will be either:

1.11.2.1 Level A and B:

18:00 hrs to 23:00 hrs as per item 597 fee;
23:00 hrs to 07:00 hrs as per item 597 fee + 50%.

1.11.2.2 Level C and D:

18:00 hrs to 23:00 hrs as per item 597 fee + the fee for Level C or D (whichever is applicable);
23:00 hrs to 07:00 hrs as per (item 597 fee + 50%) + the fee for Level C or D (whichever is applicable)

Where an urgent consultation is requested which is not considered part of 'normal after care', the medical practitioner can claim a 'not normal after care' item on the proviso that there is appropriate documentation within the medical records which supports the claim. Routine ward rounds performed after hours (i.e. not at the specific request of the hospital) on any day are considered part of normal after care and do not attract the after hours item.

If during or subsequent to the occasion of an item 597 service, further services are provided to that patient or further patients, during an unbroken period of attendance at the hospital, the item 597 fee is not chargeable. Remuneration for these services will be provided according to the SAMSOF Schedule.

1.11.3 Procedural (inclusive of Surgery and Anaesthesia) Payments

Payment for after hours procedural items (excluding Obstetric items 16515–16636) shall be:

1.11.3.1 Anaesthesia:

18:00 hrs to 23:00 hrs as per item 25025 fee + the SAMSOF fee for the procedural item;

23:00 hrs to 07:00 hrs as per (item 25025 + 50%) fee + the SAMSOF fee for the procedural item.

For the purposes of payments for item 25025, the definition of after hours shall be in line with clause1.11.

1.11.3.2 Surgical:

18:00 hrs to 23:00 hrs as per item 597 fee + the SAMSOF fee for the procedural item;

23:00 hrs to 07:00 hrs as per (item 597 + 50%) fee + the SAMSOF fee for the procedural item.

For the purposes of payments for item 597, the definition of after hours shall be in line with clause 1.11.

1.11.3.3 Epidural:

For the purposes of payments for Epidural items 18226 and 18227, the definition of after hours shall be in line with clause1.11.

1.12 Obstetric/Neonatal Care

Where a medical practitioner is called to attend a baby of a public inpatient mother, and the baby requires resuscitation and/or other significant unusual medical care outside that customarily provided (refer to CMBS (Nov 2010), Section T4.7.2) there can be a separate charge raised. This charge shall apply to the mother as the neonate is not normally a separately admitted person during the period following birth.

1.13 Caesarean Sections

The payment of non-referred Caesarean sections shall be paid as per item 16520.

1.14 Electrocardiography (ECG)

Under the CMBS there are three item numbers that relate to Electrocardiography(ECG). Item 11700 (Twelve-lead Electrocardiography, tracing and report) should only be used if a full 12-lead ECG is performed.

This item should only be paid if the medical practitioner places all 12 leads. Examinations involving less than twelve leads are regarded as part of the accompanying consultation (refer to CMBS (Nov 2010), Section D1.18).

Item 11701 (Twelve-lead Electrocardiography, report only), should be used where the ECG tracings are referred to a practitioner for a report without an attendance on the patient by that practitioner. In cases where the leads are placed by a nurse and the results are interpreted by a medical practitioner then this item should be used.

Item 11702 (Twelve-lead Electrocardiography, tracing only), should be used where the ECG tracings are performed by a medical practitioner.

1.15 Rural Health Enhancement Package (RHEP)

The elements of the Rural Health Enhancement Package (RHEP) are:

1.15.1 Eligibility requirements

1.15.1.1 Residency requirements

The medical practitioner must be a resident in country South Australia.

'Resident' is defined as being a Specialist/GP who undertakes the majority of his/her work in the country and resides in the country (i.e. outside the Adelaide Statistical Division) for four or more continuous days and nights per week, and;

1.15.1.2 The medical practitioner is in possession of appropriate:

- clinical privileges
- admitting privileges
- professional indemnity insurance, and
- RHEP and Service contract with a South Australian country public health unit

1.15.2 Availability/On-call Allowance

'On-call' is defined as being a service which has been determined to be essential by the Region/hospital (as ratified by Country Health SA) to meet the public need at a public health unit 24 hours a day, 7 days a week.

1.15.2.1 An On-call Allowance per 24 hour period for provision of after hours services at a public health unit;

- An on-call period commencing on Monday to Thursday inclusive is paid at $199.00 per 24 hour period.
- An on-call period commencing on Friday to Sunday inclusive is paid at $264.00 per 24 hour period.
- An on-call period commencing on the day that a public holiday is celebrated is paid at $330.00 per 24 period in lieu of the above rates.
- The maximum number of public holidays payable in any one year is 11.

The On-call Allowance will be indexed on 1 July each year by the Adelaide CPI.

1.15.2.2 The maximum On-call Allowance payable to the health service per service roster per annum is $84190. A service roster for each location is attached in Appendix 1.

1.15.2.3 There will be one payment only per provider in recognition of their availability. The exception to this ruling is where a resident practitioner is required to cover two locations during any one 24 hour period. The location should be within approximately 30 minutes travel by road. Practitioners who are providing on-call to two locations will attend each location as clinically necessary in that period and will be paid an additional 50% of the applicable on-call payment.

Example 'A'
A resident practitioner who is providing on-call to two locations for general medicine and will attend each location as clinically necessary in that period will be paid as follows;

- An on-call period commencing on Monday to Thursday inclusive is paid at $298.00 per 24 hour period
- An on-call period commencing on Friday to Sunday inclusive is paid at $396.00 per 24 hour period
- On-call period commencing on the day that a public holiday is celebrated is paid at $494.00 per 24 period in lieu of the above rates

Example 'B'
A resident practitioner who is providing on-call to two locations, one for general medicine and one for a speciality (e.g. Anaesthetics), and will attend each location as clinically necessary in that period will be paid as follows;

- An on-call period commencing on Monday to Thursday inclusive is paid at $298.00 per 24 hour period
- An on-call period commencing on Friday to Sunday inclusive is paid at $396.00 per 24 hour period
- On-call period commencing on the day that a public holiday is celebrated is paid at $494.00 per 24 period in lieu of the above rates

The cost of this on-call arrangement will be shared equally by the affected health units. Multiple on-call payments at one site:

- where there is approval from Country Health SA for a range of services to be available 24 hours a day, 7 days a week there will be on-call availability payable to each resident practitioner who is on the roster for an identified 24hour period
- if the resident practitioner has the recognised privileges to justify a dual role (e.g. GP Medicine and Obstetrics) they will be paid one on-call payment only

- a schedule identifying all on-call services per location will be published as part of SAMSOF. This schedule will identify all on-call services approved for RHEP payment

- any additional services must be supported by the region and ratified by the Country Health SA within the agreed service delineation framework for each region

1.15.2.4 The On-call Allowance is to be paid according to the following criteria:

- all medical practitioners required by the Region/hospital to be on-call;
- who are eligible for RHEP;
- who participate in on-call rosters; and
- who do not have any existing contractual arrangements outside of SAMSOF

1.15.3 Fee For Service Payments

1.15.3.1 Anaesthetic and Surgical Procedural item numbers shall have a loading of 20%. The full RHEP fee is shown in SAMSOF under the RHEP column.

1.15.3.2 Obstetric item numbers (16500–16636) shall have a loading of 50%. The full RHEP fee is shown in SAMSOF under the RHEP column.

1.15.3.3 Obstetric item numbers (16500–16636) are not subject to after hours loadings (refer to clause 1.11).

2 Other Allowances and Payments

2.1 Locums

GPs are entitled to receive subsidised locum support funding/allowances in accordance with guidelines of the Rural Doctors Workforce Agency (RDWA). Medical practitioners should contact the RDWA or visit www.ruraldoc.com.au/Locums/for further details regarding support arrangements and eligibility criteria.

Note – Locum arrangements specific to Specialists are included in Schedule 3

2.2 Travel Allowances

2.2.1 In circumstances where a general medical practitioner has to travel a direct route distance to a recognised hospital of more than 20km from the place of his or her nearest established practice (which must be outside of the Adelaide Statistical Division) to provide

medical services for which a Fee for Service is payable by the health unit, a travel allowance shall be payable. The allowance shall be applicable for round trips in excess of 40 kilometres.

2.2.2 A travel allowance shall be payable for specialist medical practitioners in accordance with the previous paragraph, if the specialist is resident in the region where the service is provided. In other instances of specialist travel, travelling allowances shall continue to be payable to approved visiting specialists providing services to regional and subregional health units, and to other than health units where Department of Health approval has been given for other than resident regional specialist services to be provided in accordance with the role delineation and/or service agreement of the health unit.

In the event of changes to the role delineation of a health unit, there shall be a period of notice of not less than three calendar months prior to the implementation of any change.

2.2.3 The allowance shall be based on the per kilometre rate prescribed in the 'Department of Health (SAHC Act and IMVS Act) Human Resources Manual' (Part 8 – Travelling and Expenses Reimbursement), applicable to a vehicle with an engine of more than four cylinders.

2.2.4 This allowance is to be paid once per visit, not per patient, regardless of the number of patients seen.

2.3 Attendance of Medical Practitioners at Meetings

Where the hospital requires attendance of a medical practitioner at a pre-arranged meeting regarding accreditation of a health service or as a member of a formal committee (e.g. Central Clinical Privileges Advisory Committee),a SA Divisions of General Practice rate[20]for medical practitioners attending meetings outside of practice hours applies at $72.50 per hour. Where practice costs need to be accounted for, payment is $135.00 per hour (between the hours of 8am – 6pm). Reading time applies for up to two hours at $72.50 per hour.

This fee does not apply in the following situations:

- medical practitioners appointed to a health unit or Regional Health Board by the Minister of Health
- a medical practitioner, who being a member of a health unit or Regional Health Board, is then nominated by the Board to be a member of a sub committee of the Board or as a Board representative on another Health Service or (Department of Health) committee

[20] SA Divisions of General Practice (SADI) rate – 'GP Claims Policy'

- medical practitioners on Advisory Committees (unless formal approval has been obtained from Department of Health) or Ministerial Advisory Committees of Department of Health and

- this section does not apply for the provision of payment to a Principal Medical Officer for other than health units with formal approval from the Executive Director, Finance and Infrastructure, Country Health SA, to create such a position

2.4 Telephone

2.4.1. Emergency

Where a health unit remote from the medical practitioner's usual base seeks advice from the medical practitioner by telephone, in an emergency situation, where the local medical practitioner or his/her locum/cover cannot be contacted after hours (as defined in clause1.11), a Level A consult shall apply for each telephone call if the medical practitioner is not required to see the patient.

This payment is not payable when the advice is related to medical care for which there is an “after care” component” in the fee payable to the medical practitioner providing inpatient care.

2.4.2. Overnight phone advice

Where a health unit seeks advice from the medical practitioner by telephone, where the medical practitioner is not required to physically attend, between the hours of 2300 to 0700 the following day, a payment of item number 3 per call, will be paid subject to the following:

- the payment will be restricted to the first call for each individual patient in the prescribed time frame
- this only applies to resident medical practitioners eligible for RHEP who participate in the health units on-call roster
- this will exclude calls on patients where the “after care” component is already included in the fee paid to the medical practitioner
- this will exclude all medical practitioners whose existing contractual arrangement are outside of the current SAMSOF agreement

3 Grants and Incentives

3.1 Medical Indemnity Support Grant

The Rural Health Enhancement Package (RHEP) 'Medical Indemnity Support Grant' Option 1 is available to rural resident medical practitioners, clinics or partnerships that satisfy the eligibility criteria for the RHEP. See clause 1.15 of this Schedule for more detailed information regarding eligibility. To access a copy of the RHEP Grant application form, visit the Country Health SA website at

www.countryhealthsa.sa.gov.au/medical_indemnity.asp.

Note –Specialists should note specific Medical Indemnity details in Schedule 3

3.2 Rural Female GP Pre-School Childcare Grant

The Rural Female GP Pre-school Childcare Grant will provide female general practitioners and registrars currently practising in rural and remote South Australia, a financial incentive to remain in general practice during their children's pre-school years. This grant supports the broad retention strategies of the Rural Doctors Workforce Agency (RDWA) and acknowledges the increasing contribution of female medical practitioners to the rural and remote medical workforce in South Australia.

3.3 Rural Doctors Workforce Agency – Initiatives/Grants

The RDWA also offers a number of other initiatives/grants for rural medical practitioners.

For more information visit the Rural Doctors Workforce Agency website at www.ruraldoc.com.au or telephone (08) 8357 7444.

SCHEDULE 2 – INTERNATIONAL MEDICAL GRADUATES

International Medical Graduates (IMGs), who are General Practitioners, are entitled to all clauses and entitlements of Schedule 1.

ADDITIONAL ENTITLEMENTS:

Grants and Incentives

a) Overseas Trained Doctor Specialist Upskilling

The aims of the Overseas Trained Specialist (OTS) Upskilling Program are to:

- provide training for international medical graduates seeking to achieve Fellowship of a specialist medical college in Australia; and
- support the permanent entry and retention of international medical graduates in Australia, in the areas they are most needed, so that they can contribute on a long term basis to the community and the medical workforce

Note – For more information, please contact the Chief Medical Advisor, Country Health SA.

b) Interest Subsidised Loans

The Rural Doctors Workforce Agency (RDWA) can arrange interest subsidised loans for International Medical Graduates (IMGs) who have relocated to South Australia. For more information, please contact the RDWA on (08) 8357 7444.

c) Rural Doctors Workforce Agency – Initiatives/Grants

The RDWA also offers a number of other initiatives/grants for rural medical practitioners.

For more information visit the Rural Doctors Workforce Agency website at www.ruraldoc.com.au or telephone (08) 8357 7444.

Note – Where an IMG is a Specialist, they should refer to the additional entitlements under Schedule 2, as listed above, and additional entitlements as listed under Schedule 3.

SCHEDULE 3 – SPECIALISTS

Recognition Method[21] (Specialist Definition):

- A medical practitioner who, having made formal application and paid the prescribed fee, and who:-
  - is registered as a specialist under State or Territory law; or
  - holds a fellowship of a specified specialist College; or
  - is recommended for recognition as a specialist or consultant physician by a Specialist Recognition Advisory Committee;
- May be recognised by the Minister as a specialist or consultant physician for the purposes of the Health Insurance Act, 1973
- A medical practitioner who:-
  - is training towards a fellowship of a specified specialist College; should apply to the Manager, Health Programs Branch, Medicare Australia, at any of the addresses listed in section 2.5, to be recognised as a specialist or consultant physician trainee

Specialists are entitled to all clauses and entitlements of Schedule 1 with the exception of:

1.14.2	On-call Allowance (see below)
2.1	Locums
3.1	Medical Indemnity (see below)
3.2	Rural Female GP Pre-School Childcare Grant

ADDITIONAL ENTITLEMENTS:

After Hours Attendances and Payments

a) Specialist (Consults) Payments

Payment for after hours Specialist medical practitioner services (excluding normal after care) shall be:

- 18:00 hrs – 23:00 hrs, the fee which would apply in normal hours + item 597 fee;
- 23:00 hrs – 07:00 hrs, the fee which would apply in normal hours + (item 597 + 50%) fee.

If further patients are presented during or subsequent to the occasion of a service as defined above, the subsequent services will not have the item 597 rate applied if the services are provided during an unbroken period of time. Remuneration for these services will be provided according to the SAMSOF Schedule.

[21] Medicare Benefits Schedule Book (1 November 2007), Section 5 – Recognition as a Specialist or Consultant Physician

Rural Health Enhancement Package (RHEP)

a) Immediate On-call

Specialists who are paid via Fee for Service in Country Health SA will be remunerated using the 'Immediate' on-call payments as per the current Visiting Medical Specialist Agreement 2006.

A specialist who is rostered on "immediate" on-call shall receive by way of additional payment:

- $12.30 per hour whilst on-call midnight Sunday to midnight Friday;
- $18.45 per hour whilst on-call midnight Friday to midnight Sunday;
- $30.76 per hour whilst on-call on Public Holidays.

Other Allowances and Payments

a) Managerial Allowance

A senior resident specialist who is appointed in writing by the authority of the Chief Executive or delegate of Country Health SA to undertake additional managerial responsibilities associated with the management of a clinical service will be paid an allowance as specified below (which will apply independently of the specified hours of work).

On and From First Pay Period Following			
Managerial Allowance	**Current $/annum**	**14 April 2009 $/annum**	**14 April 2010 $/annum**
Small unit	5625	6728	6963
Medium unit	13186	15784	16336
Large/Clinical Service	23188	27945	28923

These Managerial Allowances will absorb any local payment arrangements that may have been entered into (for the performance of managerial responsibilities) that have existed prior to 1 January 2007).

Grants and Incentives

a) Medical Indemnity Support Grant

The Rural Health Enhancement Package (RHEP) 'Medical Indemnity Support Grant' (Option 1 or 45% Specialist Grant) is available to rural resident medical practitioners, clinics or partnerships that satisfy the eligibility criteria for the RHEP. See clause 1.15.1 of Schedule 1 for more detailed information regarding eligibility. To access a copy of the RHEP Grant application form, visit the Country Health SA website atwww.countryhealthsa.sa.gov.au/medical_indemnity.asp.

The following clauses/entitlements are available to Specialists who are also International Medical Graduates (see also Schedule 2):

a) Overseas Trained Doctor Specialist Upskilling

The aims of the Overseas Trained Specialist (OTS) Upskilling Program are to:

- provide training for international medical graduates seeking to achieve Fellowship of a specialist medical college in Australia; and
- support the permanent entry and retention of overseas trained specialists in Australia, in the areas they are most needed, so that can contribute on a long term basis to the community and the medical workforce

Note – For more information, please contact the Chief Medical Advisor, Country Health SA.

b) Interest Subsidised Loans

The Rural Doctors Workforce Agency (RDWA) can arrange interest subsidised loans for International Medical Graduates (IMGs) who have relocated to South Australia. For more information, please contact the RDWA on (08) 8357 7444.

c) Rural Doctors Workforce Agency – Initiatives/Grants

The RDWA also offers a number of other initiatives/grants for rural medical practitioners.

For more information visit the Rural Doctors Workforce Agency website at www.ruraldoc.com.au/ or phone (08) 8357 7444.

SCHEDULE 4 – SALARIED MEDICAL OFFICERS

Award

South Australian Medical Officers Award

Department of Health Salaried Medical Officers Enterprise Agreement 2005

To access a copy of the Award and/or Agreement, visit the Department of Health website at www.health.sa.gov.au/MEDICALOFFICER/Default.aspx?tabid=39.

Conditions of Employment

- Award conditions
- Salaried remuneration
- Salary sacrifice applies
- Permanent, temporary or casual terms of appointment
- Compulsory 'Remote Call' [recall to duty]
- Medical Practitioner Group (MPG) employees progress by annual increments to a maximum rate
- Hours of duty covered by the Award
  - Maximum allowable
  - Shift lengths
  - Overtime

Entitlements

Leave:

- Annual Leave
- Family Carers Leave
- Paid Maternity / Adoption Leave
- Sick Leave

'Other' entitlements:

- Reimbursement of reasonable child care costs
- Shift penalties
- Public holiday entitlement
- Recall entitlement
- Professional development entitlement
- Examination leave (for employees classified under the 'medical administration classifications')
- Weekend penalties
- Meal breaks

SCHEDULE 5 – OTHER MODELS

Individual Contracts

A health unit seeking to enter into a contract with a medical practitioner needs to consider the following procurement information prior:

Procurement:

The Strategic Procurement Unit, Department of Health, should be consulted regarding any issues of procurement when considering individual contracts.

In addition:

- all Government entities are bound by the State Procurement Act
- these are '*contracts for services*', therefore, the State Procurement Act applies
- purchase considerations in excess of $50,000 require an acquisition plan or waive of competitive process

Acquisition plans can be approved by:

- Chief Executive, Country Health SA or General Manager to $100k
- Chief Executive, Department of Health, Accredited Purchasing Panel, Director Strategic Procurement Unit to $1m
- Minister for Health to $4m (not in budget), $11m (in budget)
- State Procurement Board no limit

Waive of competitive process approved by:

- Director Strategic Procurement Unit to $250k
- Chief Executive, Department of Health, Accredited Purchasing Panel, Director Strategic Procurement Unit to $1m
- Minister for Health to $4m (not in budget), $11m (in budget)
- State Procurement Board no limit

Contracts:

- All contracts require expenditure authorisation (as per Treasurer's Instruction No 8)
- Chief Executive, Health Service - as per delegation
- Chief Executive, Country Health SA - $200k
- Chief Executive, Department of Health - $1m
- Minister for Health - $11m
- Cabinet no limit
- Contracts are executed according to the constitution of the health service board

Licence Agreements

Licence agreements are most common where the health unit/service is owner of the medical practice.

Common elements of licence agreements often include:

- involvement in and provision of an on-call service / roster
- 'guaranteed fees' / income as derived from the annual Medical Practice income
- additional remuneration / conditions if actual activity exceeds or falls short of average or projected activity
- a 'licence fee' for the costs incurred by the health unit in the provision and maintenance of the property and other services
- a 'target' fee, which is the annual Medical Practice income which the health unit and the medical practitioner have agreed that the Medical Practice must generate in order to be viable
- Provision of a medical service from the Medical Practice
- Entry into a Fee for Service agreement with the health unit i.e. most commonly the fee structure used will be the 'South Australian Medical Schedule of Fees' (SAMSOF), Schedule 6 of the 'South Australian Rural Medical Engagement Schedule' (SARMES)
- Provision of a medical service to the health unit

Rural Doctors Workforce Agency – Business and Development Unit

The Rural Doctors Workforce Agency (RDWA) is funded under the State Governments *"Recognising the past – rewriting the future"* initiative to provide a range of business support activities to rural medical practitioners.

The RDWA's Business and Development Unit is aimed at supporting rural practice in all areas of business and practice management.

Business and Development support includes:

- provision of general business, financial and legal advice – with professional accounting and legal alliances established
- GP contract management – working with GPs and practices to develop best practice contracts and establishment of a GP contract database
- practice re-structure activities including assessing practice models
- comprehensive practice reviews – reviewing practice infrastructure, operations, staffing levels, financial viability, succession planning
- strategic and risk management
- benchmarking activities – extending the scope of 2004 benchmarking activities undertaken with solo GPs
- investigating collaboration of after-hours work