Nurse Practitioners and Paramedic Practitioners – Urgent Care Centre (walk In Clinic)

Outreach community Models of Care

Multidisciplinary team approach

Firstly, I would just like to take this opportunity to thank the LA committee for the opportunity to make a submission on behalf of NPs and PPs and as an advocate for the community of NW Tasmania.

My name is Alison Spicer, I was born and raised in Tasmania living on the NW since I was a small child. I have also lived and worked on the West Coast, and remain connected there today with family.

I have had the good fortune to work in the Tasmanian health sector for approximately 20 years. I have worked as a home care worker, RN, NUM, ADON, paramedic and now studying for my NP endorsement later this year. I have also worked internationally for a private hospital group as Nursing Consultant and CEO.

This submission is underpinned by terms 2a&b, 3a&b and term 6.

I have seen the struggles for access to Primary care across a plethora of demographics. On the West Coast, GP services are spasmodic with many shifts unable to be filled at the Strahan, Zeehan and Rosebery sites leaving people no choice but to call Ambulance for simple issues. When an ambulance service is called to simple issues it leaves the rest of the population vulnerable and without cover should an acute emergency arise. Once an ambulance meets its patient, it cannot be redeployed. On the West coast, a simple issue can encumber the only local crew for 7-8 hours including transport times to appropriate Health care provision. Once at hospital, ambulances experience ramping which can further delay emergency response and availability in that region.

In Devonport and surrounding suburbs, we simply don't have enough GPs to service the population. As you have heard in prior submissions, we also have the sickest, oldest, most remote populations and poorest health literacy in the State. Patients can wait 4 weeks or more to visit their own GP. New patients are not able to access a GP at all with many closing books. This is concerning as many mainlanders are now relocating to Tasmania increasing population growth above national average (ABS 2020) over the last few years and more are expected. Subsequently, patients are being trained to rely on ED and ambulance services to meet their Primary care needs. This is evident in ever swelling patient numbers at ED and callouts for AT. Increasing patient numbers and ramping over the last few years have seen a reactive cry from respective services for yet more acute service resources... more beds, more ambulances, more doctors, more paramedics and helicopters??

Expensive, acute service resources for primary care patients?? I will come back to this point.

In my years in healthcare, I have seen the shift in GP, ED DR population from being local residents, respected Drs invested into our communities to transient locums positioned for maximum pay, minimum time and no local commitment or engagement. Some even collaborate to drive up contract prices. Locums, while providing the point of care as advertised, have no knowledge of local health demographics and tend not to stay long enough to understand them. While Locums fill much needed gaps in GP and hospital Dr populations, they should not be considered the default service model. Locum agency staff are simply not a sustainable resource and should be used only as a last ditch measure.

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So how do we meet the health needs of regional and rural populations with declining GP populations to build a sustainable future?

The answer while complex has a simplistic premise.

We look at alternate models of care from qualified health practitioners to work to their full scope of practice and education and then incentify and upskill committed local community members to create sustainability.

I speak of Nurse Practitioners, Paramedic Practitioners, Physicians Assistants, and Pharmacy Practitioners. We only need to look across the Tasman to see what our neighbours have been doing successfully since 2016 with NPs.

New Zealand has a very similar health demographic to Tasmania and faced the same struggle to reach the primary care needs of their regional and rural communities. Instead of continuing to offer exorbitant pays and perks to Drs, they promoted the NP role and allowed access to full prescribing and testing as would a GP. Of course, the Dr groups were largely outraged and predicted the premature demise of patients and quality health care generally as a result. The politicians would not be deterred and while acknowledging the protest pressed on with the plan. Today, NPs are considered integral to NZ health care, candidates are funded on a National scheme and the education is nested to allow better flexibility and access to the role. Recent studies from NZ have found that NPs are safe and provide better access in remote regions. NZ is a glowing success story that Tasmania should look to for inspiration. I have attached for your reference some studies from New Zealand that support my comments and have quoted from them below.

"Nurse practitioners are highly skilled autonomous health practitioners who have advanced education, clinical training and demonstrated competency. They have the legal authority to practice beyond the level of a registered nurse as they hold a clinical master's degree. They may be the lead healthcare provider for health consumers and their families/whanau.

Of the 500 NPs registered with the Nursing Council in 2021, the majority work in primary care or community health. They can make diagnoses and differential diagnoses, and order and interpret diagnostic and laboratory tests. They prescribe medicines within their area of competence with the same authority as medical practitioners.

The PHO Service Agreement between the DHB and PHO allows NPs to enrol patients, receive capitation payments and claim General Medical Services in the same way as GPs".

One of our local NPs, Leahanna Stevens, is the only NP working on the North West who has now set up her own part-time private service. Leahanna has over 16 years' experience as a NP in emergency departments. She moved to North West Tasmania 6 years ago to escape the hustle and bustle of the gold coast, QLD. She has dual recognition as an Emergency Department NP and Private practice NP.

I have personally known and worked alongside Leahanna in the ED setting for 6 years and can attest to her clinical ability, integrity and patient care. Leahanna is as capable as any medical practitioner I have seen in the ED and is hugely sought after now in private practice… however she cannot make the fulltime move into private practice due to encumbrances of prescribing and billing. Even though

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Leahanna can more than competently perform full health assessments, order x-rays, pathology items, treat common conditions and perform many skills such as stitching, plastering and managing wounds, the current funding system does not allow this to be a feasible option financially … Here's why….

NP's have access to only 4 billing items, no procedures can be claimed. For a 40 minute consultation with a patient, an NP can bill around $50. This is the max NPs can get despite length of consultation or any additional procedures. The list of item numbers has not been adjusted in 10 years due to the opposition from medicine.

For a 40 min consultation, GPs can bill up to $110 plus procedures / exams they may do such as removal of foreign body $37, dressing $32, pregnancy test $12, ECG $32, plastering $132, excising a skin cancer $230 etc. The items list is available at the link below for both GPs and NPs.

Medicare_MBS-Quck-Guide-July-2020.pdf

Nurse Practitioner MBS Items Brochure_V2 (bridginghealth.com.au)

As a public servant, an NP can earn $67 per hour. So, to work in private practice, the NP would take an annual pay-cut of around $30000 under the current billing scheme unless we pass on the larger gaps to our patients, making us an affordable service to only the wealthier clientele and this is just not something nurses naturally aspire to and why the majority of NPs work in the public sector.

NPs have also been active and safe within the US since 1988. Most states have now lifted scope and prescribing restrictions to allow full practice authority (Peterson 2017). NPs and Physician assistants are the most scrutinised practitioners in health research and for 20 years have been found to be safe and effective (Barnes, Richards et al. 2018).

It is important to remember, NPs are the peak clinical leaders within the nursing stream and the highest trained nurses in their own individual specialist field. In addition, to the advanced clinical skill sets and long years of experience, NPs offer inspiration to junior nurses as a realistic and achievable career pathway for other nurses to aspire to. A viable career pathway cannot be understated in the role it plays in recruitment and retention of specialist nurses. Tasmanian senior nurses are currently leaving us to find career pathways on the mainland because there are no training positions here and they have reached the low ceilings within the THS. As a result, shortages in nursing are also filled by locum nurses. In the NW there are currently around 20 agency staff working in the Eds alone. One agency nurse would cost the THS around 50-75% more than an NP.

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Unfortunately, in Tasmania, we have only 3 training positions (2 RHH and 1 at LGH) and approx. 37 fte in the public sector. On the NW coast, there are no training positions and only 8 fte of NP positions all within the THS. There is 1 NP in private practice on the NW and to my knowledge only 4 in private practice state-wide (due to financial non viability).

In 2010 4 key recommendations to provide a transformative health care utilising nurses were developed (Shalala, Bolton et al. 2011) and I have summarised below.

1) Allow NPs to operate at full breadth of scope and education
2) Provide nurses with higher education and training through supported programs and a health education system that is seamless and accessible.
3) NPs should be included in health care redesign and be full partners with medical staff and other allied health professionals
4) Effective workforce planning that is inclusive in policy and funding of the role of NPs.

These have been implemented successfully in the US and NZ.

As far as paramedic practitioners go, innovative modelling in the UK has seen the inclusion of PPs as primary health care providers working in both private practice and ED filling the staff shortfall. PPs have clinical masters and are highly trained to operate in regional areas where resources are poor. Australia currently has 15 PPs and is growing annually. This of course would see expediential growth when actual formal recognition of the profession is acknowledged in legislation.

Previously you heard a submission from Emma Kate Thornley from ACPP (who is a PP and PA) now working in a multi-disciplinary setting taking up the GP shortfall in Ouse. I am proud to tell you this service has been an overwhelming success and further opportunities for that model are developing.

(However, Emma is not able to practice in line with her training to order tests or write prescriptions due to the lack of recognition in Tasmanian legislation).

The integration of paramedic practitioners in the UK has been so successful the NHS is now funding the model in regional areas. A recent article from the UK highlights this success, see link below.

https://www.chroniclelive.co.uk/news/health/berwick-paramedics-permanent-ambulance-service-23022190?fbclid=IwAR1PhfPimE2U276gA7uRRX1FRUa0E1bRwT1gAN3eTuh_Dbnk3jK9ZheL6Ko

Most recently the NT and Victoria have also realized the potential of NPs in their public health sector (Jennings, Lowe et al. 2021). NT last year advertised for around 25 training/candidate positions to be trained up to work in remote sites. Those positions were filled in weeks. Victoria is also progressing support for positions in the health sector and also community paramedics.

From prior submissions from NPs and PPs, I am sure you are now aware of both the great potential of these roles and how they can improve both access and quality of health care in Tasmania. You

would also have heard of the legislative/policy encumbrances that currently hamstring the profession.

So how might alternative models of care look in a Tasmanian setting.

If we consider that around 50% of patients taken to ED are low acuity and do not get admitted and around 60% of the case load of Ambulance Tasmania are primary care issues, coming back to my earlier point…why do we continue to pile resources into acute services. We need to consider diverting the patients back to appropriate care providers and investing in those pathways.

Our vision for the NW encompasses an Urgent care centre model that utilizes all appropriately qualified practitioners previously mentioned. We would see NPs, PPs, Pharmacists and a GP lead a multidisciplinary UCC where patients of low acuity can walk in and be seen and managed by trained professionals. Paramedics would be on staff to provide a community paramedic service to outreach to our most vulnerable like palliative care patients that could not otherwise travel and who routinely slip through current health care services.

Currently, some palliative care patients die waiting for services on the NW with local uptake around 3 weeks. Prior submissions have mentioned the gross inadequacy of NW palliative care services with only 1fte for specialist and .5fte for a registrar. The fallout of under resourced service falls back on ED and ambulance.

The UCC Practitioners could be hub and spoked to rural /remote regions. These would collaborate and be supported centrally back at the hub for care coordination as required. The centre would also provide a training ground for NP and PP students as well as med students to ensure sustainability and repetition of the model. This kind of service would alleviate strain on GP, ED and the ambulance service allowing these services to keep to their core business of higher acuity. Whilst Practitioner led, the centre would also employ a GP, preferably an ACRM Rural generalist who is experienced in emergency health assessment / multidisciplinary teams approach and to whom patients could be referred to if required.

Detailed modelling for an NP led UC service was completed by THS in 2019 but was overlooked in favour of yet another GP led service. I have attached a link to the paper for your perusal. Interestingly the NP led centre was one of two options but only one Np was consulted in the process whereas as fifteen doctors were asked their opinion.

Urgent_care_centre_feasibility_assessment_DoHTasmania2019.pdf (health.tas.gov.au)

I would mention, this service attracts a $150 dollar walk in fee plus billings so anecdotally has not had a dramatic impact on reducing either AT or LGH ED presentations. Any service on the northwest would have to be dramatically cheaper to be successful at improving access.

I'm sure you would agree this is a grand plan and may even seem a logical approach based on our kiwi trailblazing neighbors.

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So how can you help?

1) Obviously direct funding or access to grants would allow for immediate implementation and should be considered in health expenditure moving forward. (The Capex and Opex have been calculated out in the THS feasibility study and our UCC would be similar.)

2) Support NPs and PPs with regards to health policy and legislation for the following:

a) Recognize paramedics as health care professionals (AHPRA already does this but legislation has not been updated) and be able to seek jobs outside ambulance sevrvices.
b) Replace "medical practitioner" with "qualified health practitioner" in legislation (Poisons Act, Workers Compensation) so as all suitably qualified providers can access PBS and complete workers compensation packages that are currently burdening our EDs.
c) Champion us on a National level to lobby for changes to MBS for NPs.
d) Help us expand the role and training locally by lifting profiles, supporting more roles in Tasmania.
e) Help us improve access to care for our community – not everyone wants or needs to see a "doctor". Nurses and paramedics are longstanding trusted professions for good reason.
f) Reduce the burden of debt from the locum workforce – this is now an outdated expensive band-aid to our health system.
I would just like to give you an example of what the locum workforce costs us, the taxpayers. Currently there is a Tasmanian remote facility looking for a locum GP. The going rate is $4000 per day. This equates to 1.5 million per year. The contract length is 3 weeks at a time. $84000. The doctor in this facility would likely see 2-4 patients a day and provide an on-call service overnight. $84000 for 3 weeks work to see max 40-80 patients in total. And the RACGP and AMA are suggesting we should improve renumeration further!!
For 1.5 million we could staff an UCC with a part time GP, 7NPs and 2 trainees for a year. The UCC could service 40 pts per day.
And Finally
g) Accept the evidence over opinion> If not already you will hear the opinions of the medical fraternity that alternative models of care work well as long as there is a GP in place to supervise….That NPs should "not have access to full practice authority of a GP"…….. "NPs are not safe in independent practice and at best provide a second-tier service……"
This is opinion not fact. To be frank, it must be either ignorance of the role or as quoted on Tasmania Talks a few months ago by the Federal shadow Health Minister "turf guarding." However, once a doctor understands and experiences the role of NPs there is very little opposition… Another quote from NZ

"A GP recently said to me that when I first became an NP he was very nervous about the whole thing. He thought, here was somebody who was going to take patients away from his care, not look after them properly and then hand back all the problems. Now he wants to see more people doing the same job! He really appreciates the value I add to patient care and he has referred quite a number of

patients to me. "Some people have tended to think of us as 'mini' doctors, but I am absolutely adamant that I am not taking the place of a doctor. I am adding the value and quality to patients' care that only nurses can bring"

https://www.nurse.org.nz/user/inline/1851/nurse-practitioners-a-healthy-future-for-nz.pdf

Lets please observe the evidence! I will reiterate that NPs, PPs and PAs have been scrutinized since inception in 1988. Study after study has failed to show us as anything but safe and effective health care providers. Most recently New Zealand has categorically proved NPs work as a strategy to target this exact issue.

Ladies and gentlemen, its' time for innovation and to invest in health continuity for our communities as well as support and invest in the health care professionals who are committed to live, love and play in our amazing island state for the long term! Lets' stop waiting and watching the successes of other states and countries, get off the Locum hamster wheel and commit to the path for improving our own backyard.

I would like to thank the Committee again for the opportunity today and welcome any questions/comments.

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Shalala, D., et al. (2011). "The future of nursing: Leading change, advancing health." Washington DC: The National Academy Press. doi **10**: 12956.

Raghunandan et al. BMC Health Services Research (2021) 21:418 (2021) Examining non-medical prescribing trends in New Zealand: 2016–2020 https://doi.org/10.1186/s12913-021-06435-y

Links to NZ NP success

https://www.nurse.org.nz/examples-of-np-job-descriptions-business-case-proposals.html

https://www.nurse.org.nz/npnz-information-for-employers.html

https://www.health.govt.nz/about-ministry/information-releases/regulatory-impact-statements/health-practitioners-replacement-statutory-references-medical-practitioners

https://www.health.govt.nz/about-ministry/legislation-and-regulation/changes-health-practitioner-status

https://www.health.govt.nz/our-work/nursing/nurses-new-zealand/nurse-practitioners-new-zealand

https://www.health.govt.nz/publication/evaluation-nurse-practitioner-education-programme

https://www.health.govt.nz/our-work/primary-health-care/about-primary-health-organisations/primary-health-care-providers

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