Health Professionals Prescribing Pathway

Key Definitions

HWA will use a definition of 'prescribing' that draws upon the description by Nissen and colleagues (2010)[1] as an iterative process involving the steps of information gathering, clinical decision making, communication and evaluation which results in the initiation, continuation or cessation of a medicine. The HPPP project does not propose to address the ordering of treatment modalities other than medicines.

A prescriber is defined as 'a health practitioner authorised to undertake prescribing within the scope of their practice'.

Drawing upon the Therapeutic Goods Administration definition, medicines are defined as "therapeutic goods that are represented to achieve, or are likely to achieve, their principal intended action by pharmacological, chemical, immunological or metabolic means in or on the body of a human or animal".

1. A nationally consistent health professionals prescribing pathway - need, impact and acceptability

There is considerable evidence documenting the pressure on the Australian health system. The *National Health and Hospitals Reform Commission Report* (2009)[2] discussed large increases in demand for health care, equity of access for all Australians, financial sustainability of the system, workforce shortages and a fragmented health system as challenges facing Australia. The report also recommended that the roles of health professionals be expanded where appropriate and utilised to address some of the service equity gaps to cope with the growing demand. Assisting the medical workforce to concentrate their specialised skills or services requiring their expertise could have significant benefits for managing demand and access issues within the system, particularly in underserved communities.

Prescribing by a wide range of health professionals is already occurring in Australia. Nurse Practitioners, Dentists, Optometrists, Midwives and Podiatrists are prescribing in accordance with the legislative provisions enacted by States and Territories. However, there is no nationally consistent approach within which all health professions may safely and competently prescribe within the law and their recognised scope of practice. This deficiency has lead to inconsistent arrangements for key prescribing elements including education and training, accreditation, professional registration recognition and endorsement and ongoing maintenance of prescribing competence.

The NHWPRC report by Nissen and colleagues (2010)[1] outlines a case for the assignment of prescribing rights for qualified and accredited health professionals, other than medical practitioners. The intended aim is to assist consumers and patients by providing access to safely prescribed medications through these health professionals practicing within their recognised scope of practice.

Prescribing by health professionals other than medical practitioners has international precedent although the research regarding prescribing by health professionals varies in quality and focus. The

United Kingdom (UK) opened the British National Formulary to independent pharmacist and nurse prescribers in 2006. Recently, the Department of Health in the UK completed a comprehensive review of the evidence supporting prescribing by pharmacists and nurses[3]. After conducting a multi-dimensional analysis including surveys of patients and practitioners, case study sites, and peer reviews of pharmacist and nursing prescribing cases, the review found that prescribing by qualified pharmacists and nurses is safe, clinically appropriate, acceptable to patients, viewed positively by other health professionals, and becoming well integrated into health services. Other UK reports[4] have found that prescribing by health professionals other than medical practitioners is safe and acceptable to patients and other clinicians and that its benefits can include faster access to medicines, time-savings and improved service efficiency.

1a) What principles should underpin a national approach to health professionals prescribing? Examples could include the importance of safety and quality, or the maintenance of practitioner competence.

Apart from patient safety and prescriber competence, the Australian Physiotherapy Association (APA) believes that the following principles should underpin the national approach to health professionals prescribing:

Principles should be based on addressing the patient's needs by adequately trained professionals rather than limiting prescribing to the medical profession because of historical reasons. For example:

- In Australia, physiotherapists are primary contact practitioners and have extensive training in diagnosing musculoskeletal conditions such as shoulder injuries (often providing recommendations for management including advising GPs on the need to prescribe to manage diagnoses). When a patient presents to a physiotherapist with a painful shoulder,should the physiotherapist determine that a corticosteroid injection is appropriate as well as a course of physiotherapy to treat the patient's condition, it is necessary for the patient to see a GP who may then refer the patient on for an ultrasound guided injection. Following the injection, the patient then returns to the physiotherapist to complete treatment.
- In contrast, in the UK, physiotherapists with appropriate additional training are legally able to inject shoulder joints, Hence, the entire care episode is managed and delivered by one appropriately trained clinician, thereby minimising the need for multiple consultations which burdens the patient and the healthcare system.

Principles should include patients being able to have their needs addressed in a timely fashion. It will often take several weeks to get an appointment with a GP for prescription of a new medication or renewal of an ongoing prescription that could be safely and effectively prescribed by someone other than a doctor.

Principles should include allowing Physiotherapists to continue to operate as autonomous decision making health professionals. This would mean placing the onus of responsibility upon the Physiotherapist to practice within their individual scope which would include prescribing within the limits of their individual skill, knowledge and training.

1b) Will a nationally consistent approach to health professionals prescribing, covering important principles such as those listed above, support improved access to health services, efficiency of the health system and help address health workforce issues within the Australian health system?

Please provide further explanation and, if possible, practical examples to support your view.

The APA firmly supports a nationally consistent approach to health professionals prescribing that is grounded in the above principles. We believe that a consistent approach will improve access to health services and efficiencies across Australia, including regional and remote areas with workforce issues that limit the existing pool of prescribers and create barriers of access to certain scheduled drugs for patients. For example:

- Physiotherapists working in hospital emergency departments still require medical practitioners to prescribe medications. Allowing independent prescribing within the limits of the individual's skill, knowledge and training would improve workflow and efficiency.
- Osteoarthritis Hip and Knee Services (OAHKS) patients are often found to not be prescribed the optimal medication to manage their condition by their medical practitioner despite the existence of recognised medication guidelines. Independent prescribing would remove the need for physiotherapists to require the patients to visit their medical practitioner again for a review of their prescription, and may improve evidence based prescribing in this area.

As per the example above – nurse practitioners, optometrists and podiatrists have demonstrated that limited prescribing can be achieved safely and effectively. It has long been recognised in non-medical professions that GP's are not able to always meet with increasing demands on their services and the need to keep up to-date with ongoing education in all areas of medicine, and consequently may not be the most appropriate clinicians to deal with some presentations – e.g., musculoskeletal conditions such as back pain.

2. Potential prescribing models for a health professionals prescribing pathway.

A variety of prescribing models are utilised by health professionals internationally. The prescribing models vary in the tasks undertaken by the health practitioner; the medicines available to prescribe; the regimens under which medicines can be prescribed; and the level of supervision under which the health practitioner works. Any health professional prescribing model must have the safety of patients and consumers as paramount considerations.

The NHWPRC report by Nissen and colleagues (2010)[1] proposes four levels of prescribing for examination of applicability and appropriateness in the Australian setting, based on a graded level of autonomy to prescribe (“Prescribe to Administer”, “Protocol”, “Supplementary/Collaborative” and “Independent”). These are supported by evidence in the international literature as being safe, responsive and appropriate in international jurisdictions. However, the models chosen for a nationally consistent prescribing pathway for health professionals should not only be well-based in the literature but also based on the need to develop appropriate competencies, education, regulation and credentialing mechanisms in alignment with the varying skill sets and levels of responsibility for each prescribing level.

Experience from the UK has also suggested that evaluation of the performance of prescribing is essential so that introduced reforms are shown to be effective and patient safety is assured.[4]

2a) Should a health professionals prescribing pathway in Australia have graded levels of prescribing autonomy? Are there other options that should be considered? If so, what are they?

Yes. However, the APA believes that primary contact health professionals such as physiotherapists with adequate clinical assessment and clinical reasoning skills to form a diagnosis and who meet the prescribing competency requirements should be able to independently prescribe.

For physiotherapists who are their patients’ primary contacts and who safely operate autonomously, not possessing prescribing autonomy would be counterproductive by entrenching the existing unnecessary referral patterns – reducing productivity and increasing costs for patients and the health system.

2b) How will the health professionals prescribing pathway need to accommodate the variations of clinical settings and team environments (e.g. hospital, residential, community and private practice settings).

The health professionals prescribing pathway should not need to accommodate variations in clinical settings or team environments. It should be based on the competency of the health practitioner and not the clinical setting – this allows for transferability of skills and better

engagement of the workforce. It is recommended that training incorporate experience across a range of clinical settings where practical.

Independent prescribing should neither be a barrier to, nor impede collaborative team environments. Independent prescribers can and should ensure prescribing and other relevant health information is shared via the patients' records, and where required, work within established protocols. The APA strongly believes there is a need to shift away from the paradigm that independent prescribing would create silos.

It is important that the training pathway include the necessary competencies, for example the provision of advice about medications and administration.

3. Scope of Practice Considerations

Health professionals work within their defined scope of practice. While State and Territory legislation provides for which health professionals may or may not prescribe in their jurisdiction, matters regarding professional practice and development, inter-professional boundaries and maintenance of professional competence need to be considered in the development of a national prescribing pathway.

3a) How could professional practice and development and professional boundaries between professions be best addressed in a health professionals prescribing pathway?

The APA believes that prescribing pathways should be focussed around patient-centred care rather than the professions that have historically provided the service. Professional boundaries should not be a barrier to prescribing, and prescribing should be based on which profession is able to most safely and effectively provide care which results in positive outcomes for the patient.

> For example, a patient with mechanical back pain currently would need to see both a GP and a physiotherapist if they need certain types of analgesia and a comprehensive conservative management program. This is an unnecessary inconvenience to the patient and results in increased cost to the health system and the patient.

Each prescriber would be bound by his or her profession's code of conduct. Registration standards for endorsement of prescribing competency should state the requirements for professional development.

Boundaries may exist in specific clinical environments, however the APA believes that these should continue to be determined and managed by the protocols established within those settings.

As mentioned in 2b, independent prescribing should neither be a barrier to, nor impede collaborative team environments. Health professions need to work collaboratively to identify where boundaries may crossover, and recognise which clinician possesses the most appropriate skillsets to meet the clinical needs of the patient.

> An example of this is a patient with chronic pain. Often these patients require complex care, are on multiple pain medications, and take considerable time and several treatment sessions to establish and achieve appropriate treatment goals. Additional one on one time spent with these patients can also encourage compliance with the use of prescribed drugs. A GP may not be the most appropriate health practitioner to provide the patient with care that may be required over an extended period of time. Physiotherapists are well placed to perform this role and can develop a stronger professional relationship with patient due to the extended nature of consultations.

The APA strongly believes that the health professionals prescribing pathway should not create additional boundaries which would limit a profession to a particular scope of practice, as this will become a barrier to future innovation and improved patient care.

4. Registration and Accreditation Considerations

In Australia, the National Health Practitioner Boards may develop registration standards, codes and guidelines and approve accreditation standards to enable them to fulfil their functions as described by the *Health Practitioner Regulation National Law Act* (the National Law), which is in force in each state and territory.

In the United Kingdom, prescribers are accountable to their professional board for their prescribing and may be called to account for any medication prescribed which appears to be outside their authorised scope of practice.[1]

In addition to the registration of health professionals, accreditation authorities develop accreditation standards and accredit programs of study and education providers. The approach to these accreditation functions can vary considerably between professions.

4a) What changes to registration and accreditation practices might be needed to implement a national health professionals prescribing pathway?

Each health profession’s national registration boards would be required to develop the required nationally consistent criteria to endorse the qualifications and training of competent

prescribers. Qualification and training programs would need to be accredited and reviewed by an appropriate national agency – the APA does not have an opinion which agency this should be.

State and Territory laws need to support the national health professionals prescribing pathway and need to be nationally consistent (further detailed in our response to 7a). Prescribers should be accountable to the relevant health profession's national registration board.

4b) What strategies could be utilised in a nationally consistent health professionals prescribing pathway to ensure the safety and quality of prescribing by health professionals?

The APA believes that the following strategies can be utilised to ensure safety and quality of prescribing by health professionals:

- Establish rigorous safety and quality guidelines and mechanisms to ensure adherence.
- Establish or empower a national agency to create and maintain a nationally consistent process for accrediting courses that provide adequate knowledge and training to produce competent prescribers. Training should be interdisciplinary, but should include profession-specific modules and overarching modules to support multidisciplinary and collaborative practice (refer to 4c and 5b).
- Barriers to access to diagnostic tools such as diagnostic imaging and pathology need to be addressed. In certain circumstances, diagnostic tools are necessary to ensure the safety and quality of prescribing. Barriers such as patients not having access to Medicare rebates if not referred for such diagnostic procedures by a medical practitioner can result in the need for an additional visit to a medical practitioner. This reduces efficiency, creates additional costs for the health system and adversely affects the continuity of care. This point is further explained in our response to 5a.

4c) What accreditation requirements and considerations might exist in a national health professionals prescribing pathway? How might these requirements best be managed?

The APA believes that there should be considerations regarding the minimal standards that should be established for different health professions, based on areas of practice and skills. For example, it should be recognised that, like medical practitioners, some health professions are trained to be primary contact practitioners from the moment they start practicing. Other professions such as nurses and pharmacists are not trained to be primary contact practitioners. Therefore it is imperative that the particular assessment and diagnostic skills of a profession are recognised. Health professionals that are not trained as primary contact

practitioners need more rigorous training to develop the necessary assessment and diagnostic skills to be able to prescribe safely.

4d) Given the National Law establishes consistent processes for accreditation of programs of study, would a consistent approach across health professions to the accreditation of prescribing education be an effective strategy?

Yes. However as referred to in 4c, it must be recognised that some professions are better equipped to form a diagnosis and hence will require less training in this area. The existing knowledge between health professions will vary – for example, pharmacists will have better knowledge of medications and drug interactions than physiotherapists but have less skill in forming a clinical diagnosis. The APA believes that accreditation and clinical standards should be consistent:the content of education and training to reach these standards will vary according to the professions' basic training and scope of practice.

Establishment of a national training framework for health prescribing education and training would recognise prior learning and provide credit for areas such as clinical diagnosis and decision making skills.

5. Quality and Safety

Medication use is critically linked to patient safety. For prescribing to take place in a safe and efficacious manner, it is essential that mechanisms by which health professionals continuously improve the safety and quality of their prescribing are identified. Inter-professional communication and record management are also critically linked to safety and quality of prescribing, to avoid the risk of adverse outcomes occurring from communication breakdowns.

5a) What major prescribing quality and safety strategies should be considered to ensure the patient or consumer is protected when a prescription is provided? Who has a role in ensuring these occur? (e.g. the prescriber, the employer, the National Board)?

The APA believes that the prescriber, the employer, and the National Board all have a duty of care to ensure the patient is protected when a prescription is provided. However responsibility ultimately rests on the prescriber. The prescriber's professional national board has the responsibility to ensure appropriate standards are established and adhered to, and the employer is responsible for ensuring that the prescriber is provided with an adequate level of support and, where required, the necessary protocols .

Patient health records must be used to record prescription history and this information should be available to all health practitioners involved in the patient's care. E-health can be used to allow more efficient sharing of patient records, which would ensure better safety measures are implemented.

Further to this, as referred to in 4b, safe prescribing should be accompanied with appropriate access to diagnostic tests. To ensure safety in prescribing, health practitioners need to be able to make accurate diagnoses. Currently this can be limiting for professionals who have the clinical expertise but face barriers regarding rebatable referral to diagnostic tools such as diagnostic imaging and pathology. This can result in inconvenience to the patient, increased cost in the health system from rebates claimed for additional, unnecessary consultations, and additional workload for medical practitioners.

> For example: An athlete severely sprains her ankle. She knows she needs an assessment and a rehabilitation program for 4-6 weeks to get back to her sport and understands that a physiotherapist is the best person to provide this service. The physiotherapist concludes that the patient (the athlete) needs analgesia for 1-2 days to help manage her acute pain, however first wants to confirm there is no fracture.
>
> Currently, the athlete would need to go to a GP to get the analgesia and referral for an x-ray (to receive a Medicare rebate and not be out of pocket for the x-ray fee).
>
> Should the physiotherapist be an independent prescriber under the health professionals prescribing pathway, the athlete would be able to be prescribed the analgesia, but would still need to go to a GP if she does not want to be out of pocket for the x-ray. Access to x-ray would also be essential in establishing the optimal management for individual presentations.

5b) What communication strategies between health professionals should be employed to support safe prescribing?

Training and ongoing education opportunities could be interdisciplinary to make them cost effective, and accessible and to facilitate better communication between health professionals. However, as mentioned above in 4c and 4d, there should be consideration of individual health professions' existing skills in areas such as diagnosis and clinical reasoning.

The national agency responsible for safe prescribing should include a panel representative of all those health professions able to prescribe.

The APA supports processes that create opportunities for individual case review. Pharmacists can play a significant role in ensuring that messages to different groups of prescribers are consistent and in constantly updating prescribers with the latest bulletins from pharmaceutical companies. They can also communicate up to date advice from the Therapeutic Goods Agency.

The patient's health record should contain information about prescription history and medicines administered which should be accessible to all other health practitioners involved in the patient's care.

6. Education and Training

Appropriate education and training are necessary to support a health professional to safely and effectively prescribe, regardless of their professional background. The scope and breadth of education and training necessary to ensure a competent prescriber is not well documented in Australia. Anecdotal evidence suggests that the quality of prescribing education and training is inconsistent across Australia (Nissen 2010).

Currently, prescribing training is offered by various institutions and organisations, and through a variety of mechanisms, ranging from prescribing taught as part of an undergraduate curriculum, to postgraduate prescribing courses. Also, resources such as the National Prescribing Curriculum (NPC) modules by *NPS Better choices, Better health* are available to support and encourage rational and confident prescribing. More information is available from http://www.nps.org.au/health_professionals/online_learning/national_prescribing_curriculum. (Please use **Ctrl + mouse click** to open links)

In addition, the *NPS Better choices, Better health*, in consultation with multiple stakeholders, is currently developing a Prescribing Competencies Framework for Australian health professionals. This framework documents the core competencies required to prescribe safely and effectively, and can be used as a tool to achieve consistency in prescribing education and training. More information on this work is available at http://www.nps.org.au/health_professionals/prescribing_competencies_framework. (Please use **Ctrl + mouse click** to open links)

Any curriculum should include not only the learning objectives but also the attributes of those completing the program and methods of assessment needed to demonstrate whether the attributes have been acquired.

6a) What strategies and mechanisms should be in place to ensure Australian health professionals are adequately and consistently trained in prescribing?

As referred to above, the APA believes that the fundamental components and required competency standards of any nationally-accredited prescriber training program should be consistent across health professions. Courses must be run by approved organisations, and accredited by a national agency. The government should work with institutions to promote the accessibility of these courses.

The APA firmly believes that the government needs to provide adequate support against the cost of education and training to encourage uptake of prescriber roles. The APA has been informed that single subjects in pharmacology facilitated by one university cost over $3000 for physiotherapists. We believe that such training costs would be a barrier against health practitioners entering the prescribing pathway.

Support must also be equitable across the professions – in that same university mentioned above, pharmacology subjects provided for nurses are substantially subsidised such that the same unit costs only $1100. Such inequities may lead to an unbalanced representation of health professions in prescriber roles.

To reduce the cost and time impact of health practitioners needing to engage in postgraduate prescribing education and training on the health workforce, education providers should, where appropriate, allow components of the course to be completed online.

7. Design and implementation of a nationally consistent health professionals prescribing pathway

7a) What are the critical implementation and design factors for a nationally consistent health professionals prescribing pathway?

To ensure that a nationally consistent health professionals prescribing pathway is created, it is necessary to examine relevant state and territory -specific legislation. Drugs and poisons legislation, for example, should be harmonised to ensure that there is consistency across the states and territories for the appropriate health practitioners to provide advice, prescribe and administer medication.

The APA supports accessible, practical, and affordable training and education programs that provide health professionals with the competencies to undertake safe and quality prescribing, where clinically indicated.

The competence of non-medical prescribers, as well as safety and quality guidelines and controls, should be effectively communicated to patients to ensure they have confidence in the scheme.

Adherence to standards for ongoing evaluation of competency should be the responsibility of individual prescribers. The process to achieve this must be consistent and nationally coordinated.

8. Current and Future Innovation

8a) Do you know of any health professionals prescribing trials / projects that are happening in your area / industry? If so, please briefly describe.

The Alfred Hospital in partnership with the Victorian Department of Health are currently conducting a project around Advanced Practice Musculoskeletal Physiotherapy. One of the objectives of this project is to build the evidence base to support extending scope of practice in the area of prescribing and referring for diagnostic imaging.

Advanced Practice Musculoskeletal Physiotherapy roles have been increasing in number since 2005 and now are successfully established throughout many public hospitals nationally. It is well accepted that experienced physiotherapists can adequately work in roles traditionally done by orthopaedic and neurosurgical specialists in outpatient clinics, as well as by doctors in the emergency setting. Whilst it has been recognised that musculoskeletal physiotherapists have the clinical expertise and diagnostic skills to manage these patients as effectively as medical staff, existing legislative barriers create inefficiencies for these health professionals. These roles have been embraced by the public hospital sector. However, currently these advanced practice roles are made less effective and efficient by the inability of physiotherapists to prescribe or refer for the necessary diagnostic investigations. Clearly the law needs to recognise the skills of these health professionals and align with current practice.

The University of Melbourne's Department of Physiotherapy is exploring a pathway for prescribing rights for physiotherapists by incorporating a subject into the final year of the new Doctor of Physiotherapy (DPT) program called 'Pharmacology for Health Professionals'. This subject is a multidisciplinary subject undertaken by nurse practitioners and optometry students who currently utilise this subject as part of their accreditation for prescribing rights. A second clinically case based pharmacology subject will also be developed and will be offered for DPT students. These subjects may also be offered to physiotherapists at a post graduate level. The subjects will be consistent with nursing and optometry education requirements in order to fulfil the potential education requirements for prescribing.

9. Extra Information

9a) Please make any further comments that might assist.

The bubble plot on page 39, (figure 7), indicates that physiotherapists, as a profession, are highly protocol driven and would practice with a narrow formulary. This is far from accurate. Physiotherapists, unlike optometrists (who focus on the eye) and podiatrists (who focus on the lower limb, particularly the foot) have a wide scope of practice as a profession and do not follow specific treatment protocols but instead individually assess and tailor treatments according to their patients' needs. Physiotherapists practice across a large spectrum of conditions – for instance musculoskeletal, neurological, respiratory conditions - and with different populations – for instance women's health, aged care, and paediatrics. In addition, they treat the whole body not just a particular region as our colleagues in optometry or

podiatry. This needs to be recognised when considering prescribing rights. The bubble plot for physiotherapists should sit alongside pharmacists in the top right quadrant.

Likewise for the bubble plot on page 40, (figure 8) the bubble representing physiotherapists as individuals who work in a particular area (eg musculoskeletal physiotherapy, women's health physiotherapy) should sit in the top left quadrant, still NOT protocol driven but requiring a specific formulary according to their scope of practice or area they work in.

Page 45 contains a chart that makes reference to 'undergraduate' programs. The APA believes this should be referred to as 'entry-level' to reflect the entry-level masters and doctoral programs in physiotherapy.

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