Extended scope practitioners: our changing role in rural practice

Briony Moore, Physiotherapist, NRIC and ESP committee representative for Northern Territory APA

Introduction

The role of physiotherapists, like many health professionals, is evolving in response to workforce demands and the changing health needs of the community. The current and future opportunities for physiotherapy role expansion that will better meet the needs of our rural and remote communities can be described in three categories.

Firstly there are roles that physiotherapists are currently able to perform but where their ability to fill those roles is blocked by funding models [and/or regulation]. These roles include referral to specialists, and ordering of investigative tests.

Second, there are so-called advanced practice roles, being those that are outside the scope of what is considered normal practice, but within legislative scope. This category includes triage and screening clinics conducted by physiotherapists and other allied health professionals. In rural and remote settings, trans-disciplinary practice would also be considered in this category.

Finally, there is Extended Scope of Practice (ESP), which is defined by the Australian Physiotherapy Association (APA) as roles that are currently “outside of legislative scope”, such as injecting. Although ESP is in its developing stages in Australia and significant barriers exist to rapid implementation, there is much evidence to support its efficiencies, financial advantages and patient benefits.

Combined with advanced practice, ESP has the potential to enhance service provision in both metropolitan and understaffed rural and remote regions of Australia. This paper aims to outline the issues regarding ESP and provide an overview of current developments at state level, including supportive literature of the role.

Identified potential areas of ESP

A national survey1 was conducted in 2006 by the APA and completed by most of its National Special Groups, including standing committees such as the National Rural Issues Committee. Five main opportunities for ESP were identified and are outlined below, with justification for their implementation.

Limited prescribing rights

The potential opportunity for physiotherapists to prescribe relevant medication has huge implications for addressing general medical practitioner shortages. Depending on clinical specialty, medication such as non-opiate analgesics, non-steroidal anti-inflammatories and bronchodilators have been identified as beneficial adjuncts to physiotherapy management.

Other professionals, including nurse practitioners, podiatrists and dentists, have achieved recent legislative changes allowing them to prescribe certain substances. Optometrists have recently added a pharmacology unit to their Clinical Masters content that entitles the clinician topical prescribing rights (as opposed to diagnostic medications). Most physiotherapy undergraduate programs have some basic units on pharmacology. The Clinical doctorate program at Melbourne University has units on pharmacology and radiology that may support accreditation to practise in these areas should legislation allow. A representative from a UK University has recently been presented around Australia outlining specific guidelines and competencies necessary for prescribing for allied health professionals2 (Appendix 1).
Injecting

Again, depending on the field of physiotherapy, the ability to administer various medications could enhance the management of certain conditions commonly seen by physiotherapists. Management of spasticity and chronic bursitis with Botox and corticosteroids respectively were outlined by NRIC. Early management of such symptoms has a significant impact on outcome. In the rural setting, where it is not unusual for a patient to wait several weeks to wait to see a general practitioner, early management is not always possible.

Minor surgical procedures

Minor suturing or removal of sutures seems to be the main surgical procedure that would be useful to a rural or remote area physiotherapist. Podiatrists are currently the only AHP that have limited surgical rights.

Timely intervention with such procedures would limit scarring, maintain function and likely prevent infection when access to medical professionals is often limited.

Diagnostic imaging

Although referral for radiographic investigation such as Ultrasound, Computerised Tomography or Medical Resonance Imaging (MRI) is legally possible for physiotherapists in Australia, referrals are not or only partly covered by the Australian Government Medicare Benefits Scheme (MBS). Especially in the case of an acute sporting injury, physiotherapists are well trained to combine clinical objective and subjective findings to hypothesise a likely diagnosis, such as an Anterior Cruciate Ligament (ACL) or meniscal tear, which can be confirmed by MRI. Removing the current necessity for General Practitioner (GP) referral would reduce the time taken for accurate diagnosis and cost to both the public health system and the individual.

Pathology

Similar to diagnostic imaging, referral for pathology tests is legal but not covered by the MBS. Information that could be revealed through pathological tests including blood tests for Erythrocyte Sedimentation Rate (ESR) indicating infection, or Rh factor, indicating rheumatoid factor, can exclude or assist with more accurate diagnosis of conditions that would aid physiotherapy management.

Specialist referral and/or follow up

The health workforce document published by the APA in July 2005 recommended that patients referred by physiotherapists to medical specialists be eligible to claim MBS rebates that apply to referral by GPs. Referral to a specialist is legally within the scope of practice for physiotherapy in Australia. As a primary practitioner, money and time can be saved if physiotherapy referrals to specialists such as orthopaedic surgeons for ACL rupture, or Paediatricians for developmental delay, are facilitated by access to Medicare benefits, avoiding the need for a GP visit.

The opportunity to provide or support a follow up surgical or specialist review would also facilitate outcomes for clients and save money. While this is currently possible but seldom accessed in the public system, private physiotherapists are not able to access funding to support this service. For a client living in the north of Western Australia, a video conference with the surgeon rather than a costly flight to Perth for a routine follow up that may be brief in nature is not only cost effective but also minimises disruption for the client. Models such as this are common in mental health services. The physiotherapist can be the eyes and ears at the client’s end of the videoconference and discuss progress of treatment plans directly with the surgeon.

Additional roles

Potential additional areas of advanced or extended scope practice may vary for different areas of practice. For rural and remote practice one identified area is authorisation of patient transport.

The patient’s assisted transport scheme (PATS) or similar schemes operate in all states to provide financial assistance for patients to travel to specialist services that are not available in their home community. While there are some variations between states it is not available for allied health services.
One of the main findings in the Western Australia (WA) PATS Review of 2001 was that the current scope of the scheme has broad support, but an expansion to include some areas of highly specialised allied health services would be desirable.

Should physiotherapists gain the right to refer to a specialist, the ability to approve patient transport assistance would be essential otherwise the client will get a referral to an orthopaedic surgeon or paediatrician from the ESP and still need to go to the GP for a PATS application. One already established exception to this is that people referred for wheelchair prescription at the Rehabilitation Unit, Royal Perth, by physiotherapists or occupational therapists can receive PATS assistance. Even without ESP, the ability for physiotherapists or other health practitioners to approve PATS for eligible clients/patients could simplify the system for rural and remote residents and therefore avoid a GP visit.

Potential benefits of ESP

Establishing ESP roles for physiotherapists is likely to have many widespread benefits. The formalisation of ESP was outlined as a recommendation in the health workforce document, published by the APA in July 2005, in order to maximise the use of physiotherapists’ skills and reduced attrition.

In the United Kingdom (UK) the physiotherapy professional body, the Chartered Society of Physiotherapy (CSP), has published several relevant papers. According to their publications there is a “significant amount of research and study citing the effectiveness of ESP”.

Reduced hospital costs

- Daker-White et al found ESPs were less likely to request x-rays and less likely to refer patients for orthopaedic surgery than were sub-consultant surgeons.

Reduced waiting lists and increased throughput in outpatients clinics

- Weatherley & Hourigan show 80% of respondents in centres employing ESPs report a reduction in waiting list time. The remaining 20% who were unable to confirm this, did report a greater throughput of orthopaedic patients

- ESPs in primary care reduced the initial waiting time for patients on orthopaedic clinic appointment by over 9 months.

Demonstrated patient satisfaction

- Daker-White conclude that patients seen by ESPs reported greater satisfaction levels at follow-up than those seen by sub-consultant surgeons.

Competent management of uncomplicated cases

- Hattam & Smeatham show that ESPs in primary care can effectively manage the majority of patients awaiting an orthopaedic clinic appointment—72% of patients referred to orthopaedic clinic did not need to be seen by a consultant.

Use of physiotherapists in Emergency departments

- Hourigan & Weatherley show that physiotherapists in an ESP role can maintain the level of care to patients and enable the surgeon to be deployed more productively.

- Durrell highlights the added value of the ESP in freeing up medical colleagues to assess those referrals who need a surgical or medical opinion.

- Hourigan reports that 96% of 65 consultants surveyed expressed a high degree of satisfaction (73%) or satisfaction (23%) with physiotherapists undertaking an ESP role.

Since a dedicated allied health team, comprising Physiotherapist, Occupational Therapist and Social Worker, was introduced into the Emergency Department (ED) in The Alfred Hospital, Melbourne, in
October 2001, average length of stay in ED has been reduced by a third, particularly in people aged over 65. The number of patients admitted to the hospital from the ED has been reduced.11

This is particularly relevant in rural and remote areas, as, hospital emergency departments are used more as a source of primary care services in rural areas than in cities. In addition to these researched benefits, ESP in a rural and remote setting also has the potential to facilitate the following:

**Decrease burden on strained and aging General Practitioners and decreased cost of unnecessary GP visits**

Despite emerging evidence that investment in allied health services results in cost savings for the government and enhances the recruitment of GPs to rural areas, the bulk of rural support and incentives, in terms of both policy initiatives and financial input, continues to be directed at medical practitioners.12 By extending the scope of responsibilities of physiotherapists, GPs would have less time taken up for basic tasks such as ordering scans or writing specialists referrals, freeing up hard to get appointments.

This is a salient point particularly given the aging GP and nursing workforce in rural areas. The rural GP and nursing workforce is significantly older than in the city.13 The recent DHS Victoria Physiotherapy Labour Force Study cited 2004 Physiotherapy Registration Board data showing that approximately one-third of physiotherapists were under 30 years of age. This compares with an average age of the medical workforce in 2002 of 46.6 years, with 32% over 55, which suggests physiotherapy is more likely to have a sustainable population base than some other professions.

**Improve and enhance access to health services, particularly in remote/rural areas and provide faster access to treatment**

Figures from studies indicate that populations across Australia have significantly decreased access to allied health professional (AHP) services with increasing degree of remoteness14. ESPs are likely to be offering services within communities that are currently only sporadically available and will assist holistic patient care. A survey conducted by SARRAH in 2004 showed that more physiotherapists compared to other AHP worked in remote areas; they are thus well-positioned to increase the provision of health care.

**Optimise and strengthen relationships already established in communities while limiting disruption of communities and likely increase compliance and more co-ordinated approach to care**

Some aspects of ESP, for example specialist referral, could facilitate management of Indigenous populations within their community rather than requiring costly relocation to bigger centres. Indigenous clients are often reluctant to relocate from their own communities in order to access services.15

Experienced practitioners have identified the fact that continuity of care is important, and Indigenous populations respond best to dealing with people they know. This is especially vital in communities where English is a second language, although the evidence to support this is anecdotal. A clinician with broad skills may be able to facilitate more intervention options and thus a more co-ordinated approach to care.

**Improved ability to manage complex problems found in rural and remote Indigenous communities**

A recent survey conducted by the APA identified the need for more preventative services including asthma management, heart disease management and prevention, early intervention programs for children with disabilities, falls prevention, baby handling and child development education, injury prevention, osteoporosis management, diabetes management and prevention and management of pelvic floor dysfunction.15

Rather than accessing primary care, Indigenous populations tend to wait until the condition worsens and findings of the study indicated the main problems were mainly preventable and best managed in the communities. ESP findings may contribute to early diagnosis and thus improved management.
Potentially improve retention rates and improved job satisfaction

Struber concluded that what is lacking in current strategies to retain and recruit allied health professionals is an overarching approach at a profession-wide level and the ability of AHP training organisations to keep pace with the rapidly changing face of rural health service provision. A potential benefit of ESP described by the National Health System (NHS) in the UK, is provision of career paths for physiotherapists and allowing physiotherapists to fully employ reasoning skills.

Increased remuneration for ESPs would be likely to result in increase in upskilled AHPs in rural and remote areas. Clinicians who wish to specialise or progress their careers are largely lost to the rural workforce as there are limited promotional pathways outside metropolitan areas.

Impact in rural practice

One of the most significant issues affecting the provision of health care in rural and remote areas is the tyranny of distance. As previously mentioned, people living in rural and remote areas have reduced access to health services. Access to an ESP clinician with advanced clinical skills and broader management options has the potential to improve access to services and to have a substantial impact on the community, particularly when appropriate workforce numbers are met.

Potential concerns

The most controversial aspect of ESP among physiotherapists and among the wider medical community appears to be in regard to injecting rights. Physiotherapy training in anatomy and surface anatomy equips clinicians with a good basis for this skill but additional training, as occurs in the UK, would be essential before injection is included as part of our physiotherapy clinical roles. Significant threat of litigation and risk to professional reputation may exist unless sufficient training is provided. Insurance may also be an issue. Injecting skills need practice to be maintained so demand for this skill needs to be sufficient to ensure regular use and thus proficiency.

Resistance from the Australian Medical Association (AMA) and other parts of the medical community is a concern, with consensus vital prior to successful ESP implementation. Recent medical media includes an article headlined “Physios make grab for GP turf” where the President of the AMA highlighted there is “no short cut to medical training”. APA President, Peter Fahey, responded in a positive article, titled “Physios: we don’t want to be doctors” that outlined the likely benefits of ESP to the health system as a whole.

In developing a new ESP role, care must be taken that demands on the physiotherapist are not too high, especially in rural and remote areas where clinical roles are already often expanded and work hours longer compared to city environments. ESP development (and trans-disciplinary models of care) will not address inadequate service levels so will not solve the problem of equity of access to health care. Trans-disciplinary models and community control of primary health care services approach may work best in remote areas where horizontal rather than vertical extension may be more appropriate.

Another issue surrounding expanding the role of practice is that of remuneration. The challenges and advanced skills associated with rural practice, and the increased pressures associated with initiating new services, are seldom acknowledged by organisations or reflected in salary structures.

Current examples of advanced practice and ESP state development for physiotherapists

New South Wales

- Established a website targeted at ESP. The idea is that anyone could put ESP or AP ideas/projects on that website;
• Investigating physiotherapy representation for input into the re-design of parts of the NSW Department of Health.

Queensland
• ‘Fit for Surgery’ project: Orthopaedic screening clinics in which physiotherapists working in primary contact positions assess and manage referrals from GPs into orthopaedic departments. Clinics currently operate in 5 sites across QLD.

• Qld Health are supportive, considering broad workforce reforms and are open to allied health professionals doing other roles including in ED. X-ray ordering now possible in public hospitals by physiotherapists.

South Australia
• South Australia is the centre for the nurse practitioner model so this may influence development of ESP for physiotherapists

Victoria
• Currently talking to the Victorian registration board about legislative change.

• Clinical doctorate program at Melbourne University has units on pharmacology and radiology that can support AP.

• Victorian Department of Human Services (DHS) is conducting a regulatory review, looking at roles in emergency, intensive care and anaesthetics. There are already some primary contact physiotherapists in AP in the public sector in musculoskeletal and triage of different orthopaedic conditions. Studies on 3 outpatient and 2 emergency department roles are being conducted in Victoria under Better Skills, Best Care workforce design project.

Northern Territory
• Following the Bali incident, one physiotherapy position was funded through the trauma fund to work at Royal Darwin Hospital. There has been a physiotherapist in that role for a year and funding will continue in 2007.

Tasmania
• A state-wide rehabilitation project, prioritising waiting lists for hip and knee replacements is under way. A physiotherapist is also co-ordinating the adult cystic fibrosis service.

Western Australia
• The Internal Relations committee of the APA has been engaged in workforce consultations to consider appropriate remuneration and workforce career structures for physiotherapy, resulting in a local submission on workforce and a number of forums.

• The Health Department have an overarching ‘Healthy Workforce’ committee and under that ‘A Health Professionals Strategic Workforce Committee’ with Area Health Services, of which 3 on the committee are physios, and includes discussion about ESP. Lobbying to Director-General and Minister regarding wait-list management, improved use of the workforce, medical assistant practitioner roles and advanced practitioner roles.

• Funds available for advanced practitioner roles in musculoskeletal back-pain clinics and will have funding to set up three triage physiotherapists in Orthopaedics.

• Meetings have been held with legal representatives from the optometry and podiatry associations regarding the Poisons Act.
Future directions

By definition, ESP status in Australia involves legislative change and so should be considered a medium to long-term goal. The NHS, who provides a single body independent in decisions and implementation, facilitated establishing the ESP roles for physiotherapists in the UK. Health in Australia is subject to different State systems and legislation.

Recommendations for successful implementation of physiotherapy-led screening clinics in Australia have been made.22 Although considered more advanced practice, widening the possible scope for physiotherapy intervention in ED is also possible in the future to include such areas as:

- impaired mobility in aged patients
- falls
- back pain
- other musculoskeletal pain
- acute sports injuries
- chronic respiratory conditions
- overdose/aspiration pneumonias
- trans-ischaemic attacks.

Ensuring appropriate levels of training and experience of clinicians aiming to perform ESP roles will be vital for successful implementation of ESP. Competencies and courses or modules similar to those being developed for the nurse practitioner model need to be established and should be easier to facilitate with such programs already under way. Expansion of current undergraduate training is also being investigated. Although competency documents utilised in the UK exist and will be useful as guidelines, these may be best composed in conjunction with local medical institutions to address local needs.

Expanding technology may play a future role in assisting ESP and advanced practice development in rural and remote areas. Mentoring provides a demonstrated cost effective alternate model for providing professional and personal support and videoconferencing may also be very useful.

Whether ESP will develop in line with current changes in the physiotherapy Specialisation pathway remains uncertain. ESP may be considered as an extension of clinical specialty and thus once clinicians are specialists, they will follow on to undertake ESP roles. Alternatively, aspects of ESP may be achieved through specific modular training. This approach may be more feasible for rural clinicians or ‘generalist specialists’.

A position statement regarding ESP for physiotherapists as a result of the nationwide survey previously discussed is currently being developed by the APA and should be completed in 2007. This statement will progress the profession’s understanding of the development and direction of ESP for physiotherapists in Australia. Liaison with other health professionals similarly expanding their roles whilst ensuring the wider community are informed about changes, will best facilitate effective and successful implementation of ESP.

References


11. Oldfield, L. Senior physiotherapist Alfred Hospital personal communication, January 2007


18. “Physios: we don’t want to be doctors”. Medical Forum (WA) December 2006


20. The APA position statement on sole rural and remote physiotherapists (Nov 2004)


Bibliography


Battye, K (2003). The North West Queensland Allied Health Service Key Impacts and Recommendations – A Brief Report to Mr Chris Gill of RHAC.


Current issues for Australia’s rural and remote health workforce May 2004. NRHA position paper

The APA position statement on Indigenous Health (May 2002)


Specialism and specialists: guidance for developing the clinical specialist role. Chartered Society of Physiotherapy. August 2001 accessed October 2006
APPENDIX 1

Sample of the content of The Diploma in Injection Therapy course

Diploma in Injection Therapy

INTERMODULAR WORK CONTENT

Supervised practice

Please arrange for your supervised clinical practice to commence as soon as possible after Module A

- A minimum of six peri-articular and four intra-articular injections will be performed under supervision during clinical placement (four peri-articular and six intra-articular injections for rheumatology physiotherapists)

- The mentor who supervises this may be a medical practitioner (more than one may be used). An approved physiotherapist may supervise up to 5 injections (if necessary, please contact the administrator for one in your area). It is most important that you begin organising this immediately on being accepted for the course.

- It is best for you if your doctor mentor has attended Orthopaedic Medicine courses as he/she will understand the approach you are using. If this is not possible please ensure they are happy to allow you to use the methods we teach. The injection textbook will make this clear. (Further copies are available for purchase if required).

Enclosed you will find:

- a letter, guideline and assessment sheet - to be given to your supervising mentor/s
- an injection therapy log sheet - to record intervention and outcome
- a patient satisfaction form - for your patients’ assessment of treatment and outcome

Case Study

The case study must incorporate theoretical aspects of the condition and rationale in selection of injection therapy, referring to studies on the efficacy of this approach (see guideline).

- Bound with name of student and title of study and lesion on cover
- double-space typed on A4 paper
- maximum of 3000 words excluding references and abstract

MODULE B CONTENT

Each student should prepare a 5 minute informal case presentation of an interacting patient, with a few minutes discussion. Practical skills are reinforced, together with discussion of any communication or clinical problems, or adverse reactions encountered. A preview of the exam format also aims to build general confidence.
Appendix 2 Physiotherapists

As part of their pre-registration courses all physiotherapists will have:

- significant subjective assessment and interviewing skills and be used to applying these in a range of settings.
- well developed objective assessment and handling skills and have applied these in a range of settings and with a variety of different pathologies.
- good clinical reasoning skills and applied these in a range of settings.
- good decision making skills related to a range of clinical settings.
- an understanding of pathologies of a range of conditions.
- good reflective practice skills both theoretical and applied. Most physiotherapy courses use reflective practice as a learning tool across all levels.
- experience of critically evaluating literature, this skill is developed across all levels but physiotherapists may demonstrate differing levels of ability particularly where they have come from a diploma background.
- a basic knowledge of pharmacology relating to a limited range of medicines. This may relate purely to drug management or it may be more applied to show the interrelationship between drug therapy and physiotherapy intervention.

At a postgraduate level some physiotherapists may:

- have undertaken education in order to use injection therapy to manage, for example, musculoskeletal injuries.
- have experiential knowledge of a range of medicines related to their area of expertise.

2 ENTRY REQUIREMENTS

The safety of patients is paramount and the entry requirements focus on protection of patients including:

- professional services and new roles

occur and b) that potential prescribers are in roles which require such development.

All entrants to the programme must meet the following requirements:

2.1 Be registered with the Health Professions Council in one of the relevant Allied Health Professions

And

2.2 Be professionally practising in an environment where there is an identified need for the individual to regularly use supplementary prescribing

And

2.3 Be able to demonstrate support from their employer/sponsor including confirmation that the entrant will have appropriate supervised practice in the clinical area in which they are expected to prescribe
And

2.4 Have an approved medical practitioner, normally recognised by the employing/Health Service commissioning organisation a) as having experience in a relevant field of practice, b) training and experience in the supervision, support and assessment of trainees, c) who has agreed to;

- Provide the student with opportunities to develop competencies in prescribing
- Supervise, support and assess the student during their clinical placement

And

2.5 Have normally at least 3 years relevant post-qualification experience.

2.6 Programme providers must ensure through pre-programme assessment or from clear documented evidence that candidates have appropriate background knowledge and experience and are able to study at academic level 3

Presenter

Briony Moore is an inaugural graduate from Charles Sturt University Albury in Physiotherapy. As a student her major final year placement was in Port Hedland, Western Australia, with the assistance of a Rural and Remote Scholarship. Upon graduating, Briony contemplated working in remote Australia but chose more clinical supervision in a major rural hospital in Hobart. After working at the Royal Hobart Hospital and briefly at private practice, overseas travel beckoned. On returning home to Australia this year, Briony is now working in a private practice in Darwin and is Northern Territories National Rural Issues Committee representative.