AMBULANCE EMPLOYEES AUSTRALIA (VICTORIA)

Prescribing Paramedic Practitioner

Tapping into paramedic potential to contribute to primary care in Victoria: an AEA working group proposal

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Introduction

Paramedic expansion into primary care is a growing trend in Australia and around the world, particularly in the United Kingdom. In rural and remote areas that suffer from a lack of coverage in terms of primary care provision, the paramedic workforce represents an as-yet untapped resource that could be utilised to help meet these needs. This was acknowledged by the Ambulance Performance and Policy Consultative Committee (APPCC) in its final report in December 2015, which committed Ambulance Victoria (AV) to "Research, develop and pilot new models of community paramedicine, including paramedic practitioners to provide more responsive models of care to rural and regional communities" (p.35).

A recent report commissioned by AV indicates some promising starting points for the exploration and development of such a role. The report, titled "A clinical profile of rural and regional patients accessing Triple Zero (000) or emergency departments in 2015", found that 23% of all emergency department presentations in rural areas (105,405 patients in the 2015 calendar year) presented with conditions that could be safely managed by an "ECP-type" (Extended Care Paramedic) health professional (p.16), that is to say, an ALS paramedic with additional training in primary care. Minor injuries and wound care made up the bulk of these unnecessary hospital presentations, at 59.9% and 12.7% respectively (p.47).

There is appetite amongst the paramedic workforce to expand the paramedic scope of practice into primary care in a rigorous and coordinated manner, as evidenced by the interest, enthusiasm and professionalism of the Ambulance Employees Australia Victoria Prescribing Paramedic Practitioner Working Group. We anticipate that if ambulance paramedics are supported to provide high quality primary care services to patients in rural and regional communities, patient access to care and subsequent outcomes will be improved, as will ambulance and hospital workflow. We further expect that patients in metropolitan regions might also in the future benefit from such a skill set.

The qualification model

The model we envisage comprises four distinct levels of education and practice. An ALS-qualified paramedic with five years of professional practice in the role (including one year as a Graduate Paramedic) would be eligible to apply for entry into the Prescribing Paramedic Practitioner (PPP) program. The candidate would simultaneously work on-road and undertake a master's degree. Early exit points from the master's degree would allow the candidate to achieve a graduate certificate or a graduate diploma. Completion of appropriate periods of direct supervision in Emergency Department (ED) or primary care settings would enable employment as a Community Care Paramedic (CCP) or as a Primary Care Paramedic (PCP). Completion of the master's program and direct supervision phases would deem the candidate eligible for board endorsement as a Prescribing Paramedic Practitioner. Candidates who choose to undertake an extended master's program would be eligible for endorsement as a Consultant Paramedic Practitioner.

The employment model

We believe it is appropriate for this model to be developed, piloted and overseen by AV as part of its involvement in the Centre for Research Excellence (CRE). We recommend that funding for training for these roles be made available to eligible paramedics through a range of mechanisms, including scholarships from the Department of Health and Human Services (DHHS), as well as employer support modelled off the current arrangements for MICA students in AV. We recommend that clinical oversight of PPPs within AV be centralised, rather than dispersed to the regions, in order to maximise consistency and support for PPPs. We acknowledge that such centralisation cannot be overly prescriptive, as rural locations in particular are likely to vary in their needs in significant ways. We further recommend that clinical oversight of PPPs be provided by medical practitioners or equivalent qualified persons. We recommend that selection for the first cohort of PPPs to commence in 2018. Within any selection process that would result in employer-provided financial support for PPP university studies, we recommend, in the interests of fairness, that the possibility that a candidate might be eligible for Recognition of Prior Learning (RPL) by the relevant university must not be admissible as a factor for consideration regarding the candidate's suitability for the role.

The education model

Education to expand paramedic scope of practice to primary care is to be delivered by universities through postgraduate programs. We note that there is likely to be a significant overlap of knowledge base and skill sets between PPP academic programs and Nurse Practitioner (NP) and Physician Assistant/Associate (PA) programs. As such we recommend that universities provide clarity for prospective applicants as to what kind of RPL they will be eligible for if they have completed such programs.

Prescribing Paramedic Practitioner Academic Program Outline

Prescribing Paramedic Practitioner		Entry and Exit Points	Time
Level 1 (AQF 8)	• Introduction to Medicine • Basic Application	• **Graduate Certificate** • Community Care Paramedic • (Follow a Plan)	Half Academic Year
Level 2 (AQF 8)	• Principles of Medicine • Medical Application	• **Graduate Diploma** • Primary Care Paramedic • (Adjust a Plan)	One Academic Year
Level 3 (AQF 9)	• Principles of Medicine 2 • Medical Application 2	• **Master** • Prescribing Paramedic Practitioner • (Make the Plan)	Two Academic Years
Level 4 (AQF 9)	• Law, Ethics & Public Health • Specialised Clinical Practice	• **Extended Master – Doctor of** • Paramedic Practitioner Consultant • (Expert advice about the Plan)	Three Academic Years

Figure prepared by Andrew McDonell, MICA paramedic and working group member.

Education and qualification time frames

	Application process (university-based)	Education (university-based)	Direct supervision (takes place in high-volume ED and/or GP setting)	Indirect supervision (takes place in ambulance setting)	Post-qualifying
Community Paramedic (CP)	ALS; university entrance requirements; scholarship application (DHHS or AV)	Graduate Certificate online with on-campus blocks as required	3 months concluded by appropriate sign-off	6 months concluded by appropriate sign-off	Informal oversight and support from clinical mentor
Primary Care Paramedic (PCP)	ALS; university entrance requirements; scholarship application (DHHS or AV)	Graduate Diploma online with on-campus blocks as required	6 months (with RPL for CP program) concluded by appropriate sign-off	12 months (with RPL for CP program) concluded by appropriate sign-off	Informal oversight and support from clinical mentor
Prescribing Paramedic Practitioner (PPP)	ALS; university entrance requirements; scholarship application (DHHS or AV)	Master’s Degree online with on-campus blocks as required	12 months (with RPL for CP/PCP program) concluded by appropriate sign-off	24 months (with RPL for CP/PCP program) concluded by appropriate sign-off	Informal oversight and support from clinical mentor

Academic programs

There are currently five postgraduate programs in Australia that teach to this kind of role, with a sixth undergoing accreditation. They vary in their content and do not necessarily teach to the scope of practice we have recommended (refer to table below). Universities have, however, indicated confidence in their capacities to adapt their existing programs to meet the needs of specific ambulance services.

- Monash University: Master of Specialist Paramedic Practice (Extended Care Paramedic)
- University of Tasmania: Master of Advanced Paramedicine
- Edith Cowan University: Master of Paramedic Practitioner
- Flinders University: Master of Paramedic Science (Extended Care Paramedic)
- Central Queensland University: Master of Paramedic Science (Paramedic Practitioner)
- Griffith University: Master of Paramedic Practitioner (undergoing accreditation)

Model of care

The rationale that informs our recommended scope of practice below is that paramedics practicing primary care should do so within the medical model of health care. We believe first and foremost that the key to ensuring safe practice is to equip paramedics with insight into the limits of their own knowledge and practice. It is important to know what we don't know. It should therefore be clear from the table below that a practitioner's authority to provide definitive care for their patients expands as their knowledge base of medical principles expands. This includes training in the recognition of instances where other specific health professionals will be required to meet the patient's needs, and capacity to refer the patient onto them. We envision this role as one which works collaboratively with nurses, allied health professionals, and doctors in multidisciplinary teams. We further recommend that AV develop systems of direct communication with general practitioners and other primary care providers to ensure continuity of care for patients.

Scope of practice

Graduate Certificate = "Community Care Paramedic"	Graduate Diploma = "Primary Care Paramedic"	Master's Degree = "Prescribing Paramedic Practitioner"
- Introduction to medical model/physical assessment - Introduction to referral pathways - Introduction to working with health care teams (interfacing with GPs) - Introduction to primary care pharmacology (authority to recommend patient seek S3 medications from pharmacist) - Introduction to wound assessment - Introduction to wound care - Introduction to minor injury management - Competence in basic catheter management	- Further medical model/physical assessment - Introduction to imaging and laboratory interpretations - Introduction to point of care testing (urine dip sticks, ultrasound, etc.) - Further referral pathways (limited referral authority) - Further working with health care teams (ED based) - Further pharmacology (population group prescribing under supervision) - Further wound assessment (incl. ultrasound) - Further wound care (suturing and when not to suture) - Further injury management	- Advanced medical model/physical assessment - Advanced diagnostics - Advanced pharmacology (WHO Essential Medicines list; substantial knowledge base to underpin independent prescribing) - Advanced working with health care teams (GP based)