IMPLEMENTING ADVANCED PRACTICE NURSES IN SWISS PRIMARY CARE

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Summary: Switzerland is facing a multimorbid, ageing population and a scarcity of general practitioners (GPs). In Anglo-Saxon and Nordic countries with similar challenges, advanced practice nurses (APNs) appear to be a solution by adding new capacities and suitable competencies. Even though APNs have been established in the hospital sector, Swiss primary care is at an early stage of implementing the role. Despite the lack of regulations, role models and reimbursement schemes, political uncertainties and scepticism from GPs, the first pilot projects are underway. We discuss four of these case studies and assess the achievements and remaining challenges for further implementation.

Keywords: *Advanced Practice Nurse, APN, Swiss Primary Care, Family Medicine, Nurse Practitioner*

Introduction

In Switzerland, GPs have been the single, dominant player in primary care for decades. However, due to retirements and insufficient numbers of young successors, a future lack of GPs is expected.[1] Group practices constitute mainly aggregates of GPs without nurses or other physicians. However, these models are under pressure. Administrative and technological challenges combined with the growing and changing demand for complex health services due to an ageing, multimorbid population call traditional models of care into question. As experienced in many countries, interprofessional models of care are seen as a promising solution to these challenges.[2] Of particular interest are solutions developed in the United States, the United Kingdom, Australia, Sweden, and the Netherlands which rely on interprofessional teams involving nurses in advanced roles with a master's degree, so-called Advanced Practice Nurses (APNs). The international literature shows that APNs embedded in interprofessional teams lead to high quality and holistic care for older people by bringing in new, specific care competencies.[3] Aside from tackling the needs of older, multimorbid patients, APNs can take over defined tasks that were traditionally attributed to physicians such as diagnosis and treatment with similar or better health outcomes.[4]

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Introducing APNs in Swiss primary care

In the Swiss federalist system, cantons (states) are responsible for the organisation of care delivery to their population. This federalist governance also allows for the implementation of local strategies and models of care, which are tailored to local needs. In terms of introducing APNs in primary care, some cantons referred to this option already around 2006 and started encouraging small scale projects in 2016.

> reinvent Swiss primary care by introducing APNsin interprofessional, collaborative models of care

However, a major challenge was the availability of qualified nurses and – even harder – to convince them to work in the ambulatory sector. Across Switzerland, the number of nurses with Master's degrees was around 250 in 2015. The first modules focusing on competencies for primary care offered in Swiss universities started only after 2010. Accordingly, the "academic drift" was not home made, and Master degrees were mostly obtained abroad, mainly in United Kingdom, the United States, the Netherlands or Australia). All had good career options and promising workplace development in large hospitals. Given the resistance of GPs, lower salaries and the lack of role models there were no incentives to choose primary care. Recruitment was more successful in cases where APNs had previous experience either in home care services or at clinical interfaces such as outpatient services. Interested nurses usually joined a specifically tailored university programme, based on close collaboration with interested GPs.

Accordingly, new collaborative care models involving APNs have been realised in recent years in a handful of primary care practices (PCPs) only. Moreover, the implementation of collaborative models involving APNs is hampered by a physician-centred fee-for-service system which does not foresee reimbursement of the services provided by APNs.

On the federal level, collaborative practice was endorsed in 2013 when the Federal Government approved the national strategy "Health 2020". One of the priorities included was the promotion of "collaboration between the various health care professions by adapting initial and post-qualification training, strengthening research, and creating more favourable conditions for exercising health care professions".[5] As a result, the models involving APNs were discussed in national and regional symposia and shared in a centralised database of interprofessional practice.[6]

In consideration of undertaking evaluation and research, the field of primary care has become more attractive. In the tailwind of rising public awareness of the importance of general health care to reduce costs and over-treatment, health services research has been built in strong links to primary care practitioners and transdisciplinary networks also involving health insurance and policymakers. Hence, the topic of APN introduction is on the research agenda.[7]

Four pilot projects with different starting points

The four projects outlined in **Box 1** represent about one-third of ongoing projects in Switzerland, though some operate on temporary basis. The case studies provided present the drivers, the conceptual differences and the types of arrangements that are prototypical for different project origins and contexts.

Obstacles to widespread implementation of new care models

There are factors enhancing and impeding APN integration into PCPs. Based on evaluations of some pilot studies, a review of recent publications on Swiss primary care, the analysis of parliamentary questions and expert interviews, the benefits and challenges are summarised in **Table 1**.

Discussion

These pilot projects offer the opportunity to learn from their valuable experiences, in terms of providing proof of concept, indicators for feasibility, evidence for entrustable professional activities to be performed by APNs, and confidence regarding patient safety but also acceptable compensation schemes. The latter is crucial since previous attempts to regulate advanced practice, define the scope of practice with exclusive tasks and set tariffs similar to the physicians were repeatedly rejected in the political arena. Prevailing scepticism and opposition would ultimately lead to very restrictive legislation. Therefore, the pilot projects should be discussed broadly, as they have the potential to show to policymakers and practitioners the forward-looking and patient-oriented framework for APNs.

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The four pilot projects mark a paradigm shift in primary care. They reinvent Swiss primary care by introducing APNs in interprofessional, collaborative models of care giving. The two projects in Uri and Sernftal were arranged in a "top-down" approach by politics (public), whereas the Zürich Oberland and Altstetten cases evolved "bottom-up" by GP entrepreneurs (private). While in the politics-driven projects the role and potential of an APN was not familiar to the GPs at first, the entrepreneurs took an informed strategic choice and aimed at transferring APN models which had work abroad.

Box 1: Four pilot studies of ANP in Switzerland

Case 1: "ANP Uri"

"Advanced Nursing Practice Uri" was the first project in Switzerland which was launched and supported by a cantonal government. Uri is a small rural canton along the famous Gotthard Alp trajectory. It has the lowest density of GPs in the country (n=23, 0.63/1000 inhabitants).[8] In order to ensure primary care for its population, the local government initiated and co-financed a three-year pilot project with an APN assigned to a rural family practice with two GPs. A health insurance company co-financed the project which was also scientifically evaluated to assess patient satisfaction, interprofessional collaboration between practice staff, consultation types, costs and legal aspects. The project started in August 2017 with the engagement of the APN who works on a part-time basis (50%) in this remote, potentially underserved area. The main goal of this project was to provide a "proof of concept" of an innovative care model with a focus on older, multimorbid, often home bound patients with complex health care needs. The APN visits patients at their homes as well as in nursing homes. They also take care of non-urgent, small "emergencies", and offer technical interventions such as infusions or vaccinations. In order to improve clinical skills and competencies, the APN receives mentoring and close supervision by the GPs.

Case 2: Sernftal

In the neighbouring small rural Canton Glarus, with its deep central valley between mountain ranges,the government approved and financed the pilot project for one year. In 2018, the provision of primary care services in the Sernftal, a remote side valley, was under threat as there were not enough GPs covering this region. In Glarus, the GP density is also low (n=34, 0.84/1000 inhabitants).[8] The project was proposed by the hospital of Glarus which already had employed experienced nurses with Master's and PhD degrees. The concept was to fill the gap in primary care by sending one of them to the valley. The mission was developed by an APN interested in working in both primary care and the care service management of the hospital. The goals and tasks were similar to Uri, but with significantly higher autonomy of the APN who benefitted from support and indirect supervision by hospital doctors and a GP leaving for retirement. Beyond an internal report, the experience was not evaluated. It is reported to have good acceptance by patients, the hospital and the government. Despite convincing outcomes, it is combated by the cantonal GPs association not accepting such a substitution. Hence, continuation is not assured.

Case 3: Primary Care Practice Zürich Oberland

In this PCP, skill mix innovation was based on an entrepreneurial analysis of GPs. The two mid-career owners employed a handful of other GPs on part time schemes, a psychotherapist, a dietician, physiotherapists, and an APN. The project is also located in a remote rural area. The region has a significantly lower GP density than the canton and city of Zurich (n=1448, 0.96/1000 inhabitants which is slightly above the Swiss average of 0.93).[8] This interprofessional setting does not benefit from public subsidies. From the beginning in 2016, it was conducted with a long-term perspective. The APN mission embraces care giving to multimorbid patients with complex needs, home and nursing home visits, small "emergencies", life style and ethical counselling. The project is evaluated on patient satisfaction, interprofessional collaboration, consultation types, costs and legal aspects. Evaluation is based on the same instruments as in Uri. Results show that the APN perfectly complement the GPs. The APNs scope of practice consists of activities associated in 55% with Nursing, 31% with GP tasks, 21% with psychosocial framing. The case of PCP Zürich Oberlandis financially cost-effective and sustainable.

Case 4: Medix Altstetten

This case is part of a large company which was the pioneer of GP group practices in Switzerland. The practice is located in the outskirts of Zürich. The urban, densely settled area has a significantly higher GP density than the canton Zurich *(see above)*. The manager engaged two APNs on a part-time basis in 2016 and 2018. The motivation to introduce them was to relieve GPs from their time pressure due to the increased demand for primary care services. This model of care involving APNs was initiated by the practice itself and is financed through the practice. The case has not been evaluated. However, given the size and economic potential of the company as well as its reputation and the availability of APN in the urban context it will be continued.

Conclusions

Skill mix innovations in Swiss primary care involving APNs have not yet received great public attention but are slowly gaining momentum. The first pioneers and early adopters independently demonstrated the proof of practice regarding the successful integration of APNs in primary care. All cases provide valuable and promising results and met the predefined goals. Despite the differences regarding concept, framework, ownership and implementation, the preliminary experiences and results of the projects are similar and largely positive. Experience gained is frequently discussed in conferences. In fact, these projects have already inspired and endorsed other pioneers to launch similar projects.

However, as shown in **Table 1**, the complex nature of the challenges remaining at various levels does not allow a rapid spreading of APNs in primary care across the country. At present we see

Table 1: Antagonistic drivers and forces regarding APN in primary care

+	GP shortages, higher demand and cost pressure enhance reflection on alternatives
+	Raising awareness of the need for integrated care provision to multimorbid homebound older people
+	Universities and GPs complement each other in shaping education and the scope of practice
+	Enough time for innovation and development of models embedded in local structures
+	Endorsement of innovative interprofessional models by national policies
+	Entrepreneurial GPs seizing the "academic drift" in nursing for unconventional models
+	Open-mindedness of health insurance companies regarding compensation of APN services
–	Reluctance of GPs and medical associations
–	Fear of established practice members regarding their role, e.g., with diabetes patients
–	Overhasty and exaggerated demands for regulations and tariffs
–	Federal Parliament and Government rejected political proposals to reform primary care
–	At present, only few APN choose to work in primary care

two key adverse factors. On the meta level there is a deadlock–the recent referendum launched by the Swiss Nursing Association was completely rejected in parliamentary deliberations in October 2019 but the initiators still aim to bring their exaggerated demands for regulations and tariffs to the public vote. This, in turn, encourages all political and professional opponents, as well as the Government, to freeze reforms aimed at providing flexibility in healthcare provision for chronically ill people, in primary care and care of older people, and also the adjustment of related payment schemes. At the micro level, a number of uncertainties remain – GPs perceive an implicit confirmation of the traditional model, experienced APNs have little attractors to leave the comfort zones reached in hospital settings, and the vagueness regarding payment of their services in comparison to physicians tariffs make a deliberate choice to work in primary care an alternative for the venturous only.

Encouraging initiatives taken on the meso level (e.g. new training programmes tailored towards primary care in Lausanne and Berne, a handful of cantons revising the physician-focused legislation) might help prepare a future workforce that will become effective in a couple of years.

Taking an optimistic perspective, the stagnation and non-existence of regulations have the advantage to leave room for trials and adaptation The experiences gained from these projects provide important data regarding chronic care management, role clarity, removing bottlenecks, cost containment, acceptance and patient satisfaction. Furthermore, these cases disseminate a positive message among the medical community about the potential of APNs in primary care. Moreover, the assessment of these cases and the lessons learned allow one to start outlining the blueprint for successful implementation of the APN role in Swiss primary care.

References

1 OECD, WHO. OECD Reviews of Health Systems: Switzerland. Paris: OECD Publishing, 2011. Available at: http://www.oecd-ilibrary.org/social-issues-migration-health/oecd-reviews-of-health-systems-switzerland-2011_9789264120914-en

2 WHO. Framework for Action on Interprofessional Education & Collaborative, 2010. Available at: http://www.who.int/hrh/resources/framework_action/en/

3 Morilla-Herrera JC, Garcia-Mayor S, Martín-Santos FJ, et al. A systematic review of the effectiveness and roles of advanced practice nursing in older people. *International Journal of Nursing Studies* 2016;53:290–307.

4 Laurant M, Reeves D, Hermens R, Braspenning J, Grol R, Sibbald B. Substitution of doctors by nurses in primary care. *Cochrane Database of Systematic Reviews,* 2005. Available at: http://doi.wiley.com/10.1002/14651858.CD001271.pub2

5 Swiss Federal Office of Public Health. The Federal Council's health-policy priorities, 2013. Available at: https://www.bag.admin.ch/bag/en/home/strategie-und-politik/gesundheit-2020/eine-umfassende-strategie-fuer-das-gesundheitswesen.html

6 Swiss Federal Office of Public Health. Support programme – Interprofessionality in healthcare, 2017. Available at: https://www.bag.admin.ch/bag/en/home/strategie-und-politik/nationale-gesundheitspolitik/foerderprogramme-der-fachkraefteinitiative-plus/foerderprogramme-interprofessionalitaet.html

7 Institut für Hausarztmedizin & Community Care Luzern (Institute of Family Medicine & Community Care Lucerne). Current projects, 2019. Available at: http://www.iham-cc.ch/forschung/eigene-forschungs-projekte-01.html

8 Obsan, Swiss Health Observatory, 2019. Available at: https://www.obsan.admin.ch/de/indikatoren/aerztinnen-und-aerzte-freier-praxis