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**Literature Review**  
**To Inform a Department of Human Services**  
**Project on**  
**Credentialing and Scope of Clinical**  
**Practice in Community Health**

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**August 2006**

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## 1. Introduction and Approach to Content

Credentialing and the scope of clinical practice are aspects of the broader work on clinical governance and quality in the health sector.

As part of good governance and an appreciation of the importance of clinical governance, a standard approach to 'Credentialing and Defining the Scope of Practice in Community Health' is being developed. LIME Management Group has been engaged to undertake this project which is managed by Knox Community Health Service and funded by the Eastern Region of DHS. A Project Governance Group drawn from the Eastern Metropolitan Region and chaired by Anne Lyon Chief Executive Officer of Knox Community Health Service, is guiding the project.

The project will contribute to the development of good governance structures for the community health sector. The objective is to ensure that practitioners in a particular setting provide high quality services consistent with good practice and expected client benefits by:

- Developing a model and structure for Credentialing and defining scope of clinical practice to support safe and quality service provision in Community Health Services.
- Developing guidelines and tools to support Credentialing and defining scope of clinical practice across the Community Health Sector.

This literature review is primarily concerned with how two aspects of clinical governance: Credentialing and the scope of clinical practice, are applied in community health settings. The background section focuses on issues related to the broader governance context while the section on matters of interest covers developments in credentialing and defining the scope of practice.

The literature has been sourced by the members of the VHA Clinical Governance in Community Health Steering Group and the Clinical Governance Group of the Project on Credentialing and Defining the Scope of Practice in the Eastern Metropolitan Region (EMR). We would particularly like to thank Linda McCoy, Director of Community Services, West Gippsland Health Care Group. The material supplied has been supplemented with selected documents identified by Lime Group consultants however, the literature is not exhaustive and it is likely the reader can source other information independently.

## 2. Definitions and Understandings

**Corporate governance** describes the structures and processes put in place by boards to fulfill their strategic, statutory and financial obligations. Clinical governance is a critical element of the corporate governance of health services.

**Clinical governance** as defined by the ACHS "the system by which managers and clinicians share responsibility and are held accountable for patient care, minimising risks, and for continuously monitoring and improving the quality of clinical care". It has also been defined as "The framework through which health organisations are accountable for continuously improved the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".<sup>1</sup> Clinical governance provides a way of ensuring that that quality improvement and safety systems are in place throughout a health service, at every level.<sup>2</sup>

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<sup>1</sup> Victorian Department of Human Services Primary and Community Health Branch (2004) *Community Health Services – creating a healthier Victoria* Melbourne Victoria p30

<sup>2</sup> Swerissen, H. & Jordon, L (2005) Clinical Governance in Community Health Care Settings: Evidence and Issues AIPC La Trobe University p3

**Registration** Professional registration determined by a registering authority that determines the criteria for entry to a professional body, set, uphold and enforce standards of practice (including codes of conduct and ethics) and identify conditions that lead to entry and exit from the profession.

**Credentials** are the background and experience an applicant presents for consideration when applying for a job and typically include professional education and degrees, professional registration and accreditation, work history, references and health status. Certification is a term that has been used to describe the process of verifying the truth of an individual's assertion of qualification.

**Credentialing** refers to the formal process used to verify the qualifications, experience professional standing and other relevant professional attributes of medical practitioners (and other clinicians) *and also* to form a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environment/s.<sup>3</sup>

**Defining the scope of clinical practice** follows on from Credentialing and involves delineating the extent of an individual medical practitioner's clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability, and the needs and the capability of the organisation to support the medical practitioner's scope of clinical practice.<sup>4</sup>

The term "clinical privileging" is used as an alternative to the term "defining the scope of clinical practice"<sup>5</sup>

**Accreditation** refers to the process by which a private, non-government agency or association grants public recognition to an individual, institution or program of study that meets certain established qualifications, standards or periodic evaluations. In this paper **professional accreditation** is used to refer to the accreditation of individual practitioners granted by a registering body.

### 3. Background

There are currently two governance structures for Community Health Services in Victoria: 39 are independently managed (under Section 46 of the *Health Services Act 1988*) and the remainder are part of larger health services such as Metropolitan Health Services and Rural Health Services or hospitals.<sup>6</sup> The independent services' Boards of Management have elected members and members who are appointed by the Governor in Council, on the nomination of the Minister.

The literature identifies the broader policy context that has supported an emphasis on credentialing and defining the scope of practice. The DHS *Community Health Services – creating a healthier Victoria (2004)* policy clearly positioned community health services as the platform for the expansion of primary care services particularly for management of chronic disease, health promotion and early intervention. It noted that stronger governance and effective leadership as

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<sup>3</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 p 3

<sup>4</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 p 3

<sup>5</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 p 4

<sup>6</sup> Victorian Department of Human Services Primary and Community Health Branch (2004) *Community Health Services – creating a healthier Victoria* Melbourne Victoria p30

well as improved business and quality systems, were major prerequisite to implementing this policy.<sup>7</sup>

There is also growing awareness that “The distinction between primary, acute and sub acute settings is becoming blurred. Fiscal pressure, changes in information and treatment technologies, and emergence of consumer rights and preferences have seen a dramatic shift from institutional and bed based care to community provision for more complex needs.”<sup>8</sup> The links created by the Hospital Admission Risk Program (HARP) between the acute and community sector have also highlighted the difference between the acute and community health services accountability structures. As noted in the literature “As complexity of care in primary and community settings grows, clinical governance procedures will become more important.”<sup>9</sup>

### International Developments

There is currently an international focus on the importance of good governance in health services.

The UK Department of Health has had a focus on clinical governance in the NHS Trust and Primary Care Trusts since the late 1990s and there has been parallel activity in non-departmental bodies and the public sector generally addressing good governance, as well as further afield in Europe (*OECD guidelines on the Corporate Governance of State-owned Enterprises, Dec 2004*) and the US (The Sarbanes-Oxley (SOX) Act passed in 2002)<sup>10</sup> “Boards, at the same time as concentrating on strategic and important matters, also need to be certain that all risks are effectively controlled and managed and attention is focused on the core business of the organisation – to care for and treat patients – and fully understand and meet their responsibilities...”<sup>11</sup> The NHS has developed a range of guidelines including a practical guide for internal auditors.<sup>12</sup>

The UK literature on clinical governance in primary care is based on primary care trusts which are predominately GP dominated and consequently differ from the community health service model in Australia<sup>13</sup>.

### Public Hospital Governance

The work being undertaken on governance by hospital boards is considered to have transferable learnings and is widely referred to in the literature on community health.

*In August 2003, the Victorian Public Hospital Reform Panel reported to Minister Pike on how to strengthen the governance of public hospitals. While the panel did not look at independently managed community health agencies, their key findings suggest that strengthened governance for Community Health Services would include:*

- *Boards having a clearer understanding of the government’s expectations of performance and the measures and benchmarks to be used to assess performance*
- *Improved communication and relationships between the department and boards*
- *A stronger focus on monitoring key aspects of performance*

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<sup>7</sup> Victorian Department of Human Services Primary and Community Health Branch (2004) *Community Health Services – creating a healthier Victoria* Melbourne Victoria p1

<sup>8</sup> Swerissen, H. & Jordon, L (2005) *Clinical Governance in Community Health Care Settings: Evidence and Issues* Australian Institute for Primary Care La Trobe University p14

<sup>9</sup> Swerissen, H. & Jordon, L (2005) *Clinical Governance in Community Health Care Settings: Evidence and Issues* Australian Institute for Primary Care La Trobe University p15

<sup>10</sup> Deighan M, Bullivant J, *NHS Integrated Governance Handbook* Department of Health UK February 2006 p5

<sup>11</sup> Deighan M, Bullivant J, *NHS Integrated Governance Handbook* Department of Health UK February 2006 p5

<sup>12</sup> UK Department of Health (2005) *Providing assurance on Clinical Governance: A Practical Guide* HMSO London

<sup>13</sup> Swerissen, H. & Jordon, L (2005) *Clinical Governance in Community Health Care Settings: Evidence and Issues* Australian Institute for Primary Care La Trobe University p7

- *Clearer understanding of the annual accountability cycle to structure the process of agreeing strategic plans, budgets and performance objectives and targets*
- *Improved skills and experience of appointees, and induction and ongoing training available for directors to improve the capacity of boards to govern effectively.*<sup>14</sup>

### **Legal Framework for Clinical Governance**

Swerissen and Jordon (2005) note that in addition to patient and staff safety “ the potential for litigation against health services provides a compelling reason to implement sound clinical governance systems “. <sup>15</sup> In Victoria, the Victorian Health Care Services Act 1988, Health Services (Governance) Act 2000 and Health Service (Governance and Accountability) Bill 2004 mandate that Boards of health services are ultimately responsible for safety and quality. Although no litigation case has arisen in Victoria it is possible.

### **Responsibilities of Boards of Management**

The literature acknowledges that increasingly complex services and funding accountabilities mean that board responsibilities have become more challenging and require a range of skills and experience to ensure effective governance, including clinical governance. <sup>16</sup> Accordingly the Department is working with boards in both independent and integrated Community Health Services to identify how they can be strengthened to meet the challenges and opportunities.

As a minimum requirement, boards should ensure that safety and quality management receives the same emphasis as financial management, and is linked to strategic and business planning processes. An effective quality program requires a planned approach that involves all levels of an organization. <sup>17</sup>

The literature also notes that health service quality approaches “comprise many external components such as: accreditation standards and reviews, funding and policy imperatives and tools from the Department of Human Services (DHS), national initiatives from bodies such as the Australian Council on Safety and Quality in Healthcare and ideas from programs in other countries”<sup>18</sup>.

The literature consistently notes that processes of Credentialing and defining the scope of clinical practice should be integrated within comprehensive governance systems. In the case of medical practitioners the process should inform medical practitioner appointment processes and different structural approaches are possible: a governing body, a senior manager or an appointments committee. <sup>19</sup> Regardless of the approach taken the process should be discrete and fully documented. The national standard does not mandate a specific structure but seeks to provide guidance on the proper conduct, role and composition of the body that undertakes these processes. The process should be well defined, documented, transparent, independent, within the organization’s capability and supported with accurate record keeping. The role, rules, conduct and confidentiality of committee proceedings need to be established. <sup>20</sup>

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<sup>14</sup> Victorian Department of Human Services Primary and Community Health Branch (2004) *Community Health Services – creating a healthier Victoria* Melbourne Victoria p55

<sup>15</sup> Swerissen, H. & Jordon, L (2005) *Clinical Governance in Community Health Care Settings: Evidence and Issues* Australian Institute for Primary Care La Trobe University p6

<sup>16</sup> Victorian Department of Human Services Primary and Community Health Branch (2004) *Community Health Services – creating a healthier Victoria* Melbourne Victoria p55

<sup>17</sup> The Victorian Quality Council (2005) *Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services* p4

<sup>18</sup> The Victorian Quality Council (2005) *Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services* p3

<sup>19</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 p 17

<sup>20</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 pp 17-32

## Integrated Governance

Integrated governance is a concept identified in the United Kingdom based on the understanding that although all elements of governance are important there are risks to governing in silos as strategic directions can impact on each other. Integrated governance seeks to make the alignments needed to deliver strategic objectives.<sup>21</sup> Eight elements of integrated governance are recognised:

- Resources
- Efficiency, economy, effectiveness and efficacy
- Compliance and authorisations
- Compliance with standards for better health and national targets
- Duty of quality
- Duty of partnership
- The duty of patient and public involvement
- The ongoing development of the Board

Integrated governance places the duty of quality (an integrated framework of quality, performance and governance) on organisations rather than individual clinicians and aims to mainstream clinical governance into all planning decision making and monitoring undertaken by the Board.<sup>22</sup> Clinical governance is the vehicle for improving the standard of clinical practice and protecting the public from unacceptable standards of care. “Integrated governance ‘ is a coordinating principle. It does not seek to replace or supersede clinical or financial governance – or any other governance domain. Rather re-energises their vital importance and the interdependence and interconnection between them.”<sup>23</sup>

## Quality and Culture

The literature on quality in health services gives Boards the responsibility of developing a supportive culture. “It is the responsibility of the board and senior management to promulgate a culture wherein openness, mutual respect and teamwork are encouraged and rewarded. This should provide the foundation for a planned approach to quality and safety that encompasses staff and patients’ values, identifies clear priorities, allocates resources, provides education, addresses risk, illustrates the QI methodology in use and outlines the supporting committee and reporting structures.”<sup>24</sup>

Research has shown that there are three key predictors of staff involvement in safety and quality activities: the extent of support from their direct line manager; a belief that the organisation will experience outcomes of value from the activities; and training in the tools of change and improvement.<sup>25</sup>

## Clinical Leadership

Boards should promote an understanding that clinicians have a system responsibility as well as an individual responsibility to the consumer. An effective, transparent system for credentialing clinicians must be in place with strategies to deal with poor performing clinicians. Structures for reporting and standards need to be established and trend data reported relating to adverse

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<sup>21</sup> Deighan M, Bullivant J, *NHS Integrated Governance Handbook* Department of Health UK February 2006 p17

<sup>22</sup> Deighan M, Bullivant J, *NHS Integrated Governance Handbook* Department of Health UK February 2006 p29

<sup>23</sup> Deighan M, Bullivant J, *NHS Integrated Governance Handbook* Department of Health UK February 2006 p45

<sup>24</sup> The Victorian Quality Council (2005) *Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services* p3

<sup>25</sup> The Victorian Quality Council (2005) *Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services* p5

events and errors, infection control indicators, cleaning audits, client complaints, consumer falls, medication errors, and so on.<sup>26</sup>

Clinical leadership is considered a prerequisite to credentialing and defining the scope of clinical practice in some of the literature. A supplementary paper to the Victorian 'Better Quality Better Healthcare' Framework concludes,

*Clinical leadership is essential to clinical governance and requires highly visible clinicians enacting espoused values and plans. The key practices associated with good clinical governance such as creating a 'just' culture, delegating and supporting accountability for improvement to individuals and teams, monitoring and improvement of care and services at all levels of the organisation, and identifying and addressing areas of key risk, cannot be realised without clinicians leading the involvement and support of their peers and colleagues. This will not happen by chance, but requires a planned partnership approach between clinical and non-clinical managers, facilitated by high level backing from CEOs and executives, supported by organisational structures, resources and training. An investment in effort and time will be required. Transforming care for patients and staff is not possible without clinicians leading clinicians.*<sup>27</sup>

### **Consumer, Carers and Community Participation**

Victorian Department of Human Services Primary and Community Health Branch (2004) *Community Health Services – creating a healthier Victoria* noted the importance of strengthening mechanisms for strong consumer, carer and community participation in service planning, implementation and evaluation by all Community Health Services. Participation of consumers in the governance of health services is seen as an important way of ensuring that health services meet the needs of the community and of promoting effective health planning and improvements in health care quality and safety.

The Victorian Quality Council (2005) *Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services* identifies consumer and community involvement as one of four organisational elements critical to the effective service planning and evaluation, and to the achievement of optimal care outcomes.<sup>28</sup>

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<sup>26</sup> Victorian Department of Human Services Primary and Community Health Branch (2004) *Community Health Services – creating a healthier Victoria* Melbourne Victoria p56

<sup>27</sup> The Victorian Quality Council (2005) *Evaluation of VQC Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services* Victorian Department of Human Services p9

<sup>28</sup> The Victorian Quality Council (2005) *Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services* p10

## 4. Quality Frameworks

A number of quality frameworks that promote good clinical governance are described in the literature. In February 2002, DHS released a Service Quality Framework to continuously improve the quality of services to clients. The framework identifies five quality management building blocks:

- Service user responsiveness
- Staffing and physical resources quality
- Quality assurance standards and monitoring
- Safety and adverse events management
- Quality improvement.<sup>29</sup>

More recent literature clearly places credentialing within quality and governance frameworks. The Victorian Quality Council (VQC) *Better Quality Better Health Care, Safety and Quality Improvement Framework for Victorian Health Services (2003)* provides an overview of the principles and practices necessary for effective monitoring, management and improvement of health services. The framework was developed primarily with acute health services in mind, however, the principles and framework elements, particularly those concerning clinical governance and leadership, are applicable more broadly across all aspects of service provision and care. "Its usefulness depends on the extent to which organisational and clinical leaders adapt it to local structures, environments and needs."<sup>30</sup> The framework is built on a foundation of clinical governance as defined by the Australian Council on Hospital Standards (ACHS), which clearly delineates the board responsibility for ensuring that service and care quality is addressed with the same rigor as financial governance, and ensures that corresponding accountabilities are delegated throughout the organisation.

The *Better Quality, Better Health Care A Safety and Quality Improvement Framework* identifies four key organisational elements necessary for the effective improvement of the quality of health care: Governance, Leadership and Culture; Community and Consumer Involvement; Competence and Education; Information Management and Reporting.<sup>31</sup>

The framework distinguishes "Competence of, and Education to Support, Health Care Providers" as a major priority for review and action in health services. It considers that assessing, achieving and maintaining a high level of staff competence at all levels to ensure the safe and effective delivery of health care, is both a corporate and personal responsibility. It recognises that achieving this requires close attention to recruitment, Credentialing, peer review, skills assessment, clinical supervision, recertification and continuing education.

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<sup>29</sup> Victorian Department of Human Services Primary and Community Health Branch (2004) *Community Health Services – creating a healthier Victoria* Melbourne Victoria p35

<sup>30</sup> The Victorian Quality Council (2005) *Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services* p2

<sup>31</sup>

Organisational safety and quality improvement is diagrammatically illustrated by the VQC using a matrix approach.



Source: The Victorian Quality Council (2005) *Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services*

In 2005, an evaluation of the *Better Quality, Better Health Care A Safety and Quality Improvement Framework* was done by surveying quality managers of Victorian health services.<sup>32</sup> The evaluation found the Framework was useful and practical tool for quality and safety improvements and that the way it was utilised depended on the maturity of a health service safety and quality program; for those well established it provided more of a checklist while for others it was a guide to remodelling. The findings suggested that involvement was largely confined to senior management and that participation by middle managers and clinicians was still developing. Training and education were highlighted as key elements of successful programs.

### External Quality Assurance, Critical Incident Reporting and Accreditation

The literature notes that it is a requirement of Department funding that Community Health Services participate in a recognized external quality assurance program, such as QICSA (Quality Improvement and Community Services Accreditation), EQUIP or ISO.<sup>33</sup> Community Health Services guidelines require agencies to prioritise quality and safety in service delivery, including participation in an approved accreditation program and reporting of accreditation status annually to Department of Human Services regional offices.

<sup>32</sup> The Victorian Quality Council (2005) *Evaluation of VQC Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services* Victorian Department of Human Services p7

<sup>33</sup> Victorian Department of Human Services Primary and Community Health Branch (2004) *Community Health Services – creating a healthier Victoria* Melbourne Victoria p35

The Australian Council on Health Care Standards (ACHS) released new version of EQuIP at the end of August 2006 that extends the application of the competency and clinical practice criteria agencies must meet (based on the National Standards), from “medical” staff to “clinical” staff. There is also an increasing emphasis on credentialing in the private sector, particularly the mental health areas because of the range of classifications of the staff employed. The Victorian Community Health Program requires and funds participation in accreditation.

The Australian Council for Safety and Quality in Health Care is considering current approaches to accreditation across Australia and opportunities for a more integrated approach.<sup>34</sup>

Safety and adverse events management requires systems to minimise the risk from services provided.<sup>35</sup> The department has recently reviewed its critical incident reporting system for funded agencies and the application to Community Health Services has been strengthened.

## 5. Credentialing

A core document in the literature is the “National Standard for Credentialing and Defining the Scope of Clinical Practice of Medical Practitioners” (National Standard) developed by The Australian Council for Safety and Quality in Health Care (ACSQHC) in 2004 for use in public and private hospitals. A critical part of the Council’s work is assisting health care organisations to ensure that care is provided only by qualified professionals whose performance is maintained at an acceptable level. While there has been a long tradition of health care organisations undertaking processes of Credentialing and defining the scope of clinical practice of medical practitioners, the application of these processes varied considerably creating the need for a standard. As developments in technology extended clinical practice, practitioners become more mobile and the legal responsibilities of hospitals became greater, it was recognized that credentialing processes needed to become more rigorous.<sup>36</sup>

The fundamental aims of the National Standard are to:

- Reduce harm to patients and improve the safety and quality of health care.
- Extend the traditional concepts of Credentialing and privileging (defining the scope of clinical practice) to incorporate the concept of a strong, mutual relationship between the employing or contracting organisation and each medical practitioner, on the safety and quality of health care.<sup>37</sup>

The National Standard extends the concepts of Credentialing and defining the scope of clinical practice to encompass shared responsibility for safe service provision in supportive environments. It acknowledges the importance of the input of medical practitioners in the process of improvement of safety and quality in health care organisations, and reinforces the responsibilities of health care organisations to provide resources to support the services they wish to offer.

The National Standard recognises that peer assessment and the willingness of individuals to comment on their own skills and the skills of others are fundamental to successful processes of Credentialing and defining the scope of clinical practice.

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<sup>34</sup> Victorian Department of Human Services Primary and Community Health Branch (2004) *Community Health Services – creating a healthier Victoria* Melbourne Victoria p35

<sup>35</sup> Victorian Department of Human Services Primary and Community Health Branch (2004) *Community Health Services – creating a healthier Victoria* Melbourne Victoria p35

<sup>36</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 p 7

<sup>37</sup> DHS *Credentialing and Privileging (defining the scope of clinical practice) for Medical Practitioners in Victorian Rural Health Services – a Policy Handbook* March 2006 p4

While the National Standard has been designed to apply initially to medical practitioners working in hospital settings, it was developed with a view to extending its application to support Credentialing and defining the scope of clinical practice of all health care professionals in a broad range of clinical settings.

## Principles

Principles for Credentialing and defining the scope of practice were established by the Australian Council for Safety and Quality in Health Care in the *Standard for Credentialing and Defining the Scope of Clinical Practice* and reaffirm that implementation of the guidelines is an organisational governance responsibility which complements medical practitioner registration requirements to the benefit of patients, communities, health care organisations and medical practitioners. The principles identify Credentialing and defining the scope of clinical practice as essential components of a broader system of organisational management of relationships with medical practitioners, a non-punitive process that is fair, transparent and legally robust based on strong partnerships between health care organisations and professional colleges, associations and societies.<sup>38</sup> The processes of Credentialing and defining the scope of clinical practice are conducted within the context of the mutual rights and obligations of the organization and the medical practitioner.

Credentialing is also seen as critical to the safety dimension of the VQC *Better Quality, Better Health Care A Safety and Quality Improvement Framework*<sup>39</sup> (2003) and also as contributing to the effectiveness and appropriateness of care. The framework notes:

- “Credentialing is critical to delivery of safe care and services. Credentialing procedures are designed to ensure that health professionals practice within the limits of their competence and provide opportunity for regular review and approval of the scope of an individual’s practice.
- Board, executive and senior managers should be satisfied that robust credentialing policies and processes are in place for all current clinical staff and that these are supported by appropriate committee and reporting structures.
- Participation in activities that improve the safety of care and services should be considered as an element of the credentialing and privilege process.”<sup>40</sup>

The VQC framework goes on to propose that Credentialing should be considered by the organisation on the basis of:

- Eligibility for professional registration held and current entitlement to practice
- Qualifications and training
- Clinical experience, competence and integrity
- Whether the candidates have involved themselves in quality review mechanisms including clinical audit, peer review and risk management
- Commitment to past and continuing professional education
- Satisfactory professional referee reports including peer comments
- Acceptable and safe practice as evidenced by personal history of patient complaints, professional body investigations, indemnity and legal records
- Communication skills with patients/families/communities/health care team
- Collaboration skills as demonstrated by effective interdisciplinary team activities
- Management skills

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<sup>38</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 pp 8-11

<sup>39</sup> The Victorian Quality Council (2005) *Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services*

<sup>40</sup> The Victorian Quality Council (2005) *Better Quality, Better Health Care A Safety and Quality Improvement Framework for Victorian Health Services* p28

- Advocacy skills
- Academic and/or research skills including continuing education aimed at the attainment of best practice models and practices.

### Legal Issues

Not a great deal has been written about credentialing from an Australian legal perspective however some issues were explored in an article about perioperative nursing by Chiarella<sup>41</sup>. This article notes that while the term 'Credentialing' does not carry a specific legal meaning, what can be deduced is that credentialing may well be anticipated to set up a series of legitimate expectations on behalf of patients: protection from incompetence, safety from harm and able to receive the services that the credentialing claimed could be delivered.<sup>42</sup>

Registering bodies were considered to play a key role in protection from incompetence and safety from harm. As most nurses are employees, patients sue the employing authorities vicariously for the negligence of the nurse and this way are most likely to be compensated. The expectation is that hospitals would assume vicarious responsibility for employees providing they had assured themselves they were adequately prepared and competent to undertake the tasks set.<sup>43</sup> In service programs, role policies, supervision and re-accreditation in the work place level are ways employers ensure continuing competence. Hospitals in Australia are "held to have what is known as a non-delegable duty of care: a duty to ensure the patient is safe, regardless of the status of the employee."<sup>44</sup> The article raises questions about the extent to which health services can accept the credentialing standard of a professional organisation and just what the credentialing organisation is giving an assurance about.

### Confirming Credentials

The literature recognizes that while Credentialing and defining the scope of clinical practice are organisational governance responsibilities, the collection of evidence of credentials and confirmation of their validity may be undertaken on behalf of an organisation by an external party (for example, a medical board or professional college, association or society) provided the organisation is satisfied that the external party's approach is rigorous and complete.<sup>45</sup>

The discussion paper on the Regulation of Health Professions in Victoria (2003) considered the links between credentialing of practitioners and registration boards and noted the following:

*Credentialing has the potential to provide a far more individualised and responsive mechanism for identifying and monitoring the appropriate scope of practice for a practitioner, within a health care setting, than is available via registration processes. However, there are important links between credentialing and registration. The processes and activities of the respective bodies must be complementary, and there must be good communication to ensure that the objective of protecting the public and promoting the quality and safety of health care is achieved.*<sup>46</sup>

The paper identified the links between the responsibilities and activities of a registration board in registering and regulating health care professionals, and the processes conducted by health care facilities in assessing the credentials of those practitioners and granting, refusing to grant, reviewing or withdrawing certain clinical privileges as follows:

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<sup>41</sup> Chiarella, M. "Legal Issue Relating to Credentialing" *ACORN Journal* Autumn 1999P41-43

<sup>42</sup> Chiarella, M. "Legal Issues Relating to Credentialing" *ACORN Journal* Autumn 1999P41

<sup>43</sup> Chiarella, M. "Legal Issues Relating to Credentialing" *ACORN Journal* Autumn 1999P42

<sup>44</sup> Chiarella, M. "Legal Issues Relating to Credentialing" *ACORN Journal* Autumn 1999P42

<sup>45</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 p 35

<sup>46</sup> Department of Human Services Policy and Strategic Projects Division *Regulation of the health Professions in Victoria A Discussion Paper*. October 2003 p59-60

- One of the important credentials of a practitioner is their registration status and, presumably, any health care facility undertaking a credentialing process would include a check of the practitioner's registration status with the relevant registration board.
- Suspension or cancellation of a practitioner's registration would be expected to result in the withdrawal of their clinical privileges by a health care facility.
- Similarly, where conditions, limitations or restrictions have been placed on a practitioner's registration following an impairment, disciplinary or performance assessment process, it is logical that this should trigger a review of the practitioner's clinical privileges by a health care facility.
- Where a health care facility withdraws or limits a practitioner's clinical privileges in response to concerns about their health, performance or professional conduct, registration boards have an interest in such information.

This means that there must be good communication between registration boards and those in health care facilities who are responsible for credentialing and clinical privileging. The paper noted two other issues of relevance:

- Whether there should be a legislative requirement for health care facilities to report to the relevant registration board where it has terminated the employment of a registered practitioner, and
- Whether information on clinical privileges granted by health care facilities to individual practitioners should appear on the relevant register maintained by a registration board.<sup>47</sup>

### **Establishing Essential Criteria for Positions**

The literature notes that even before an organisation recruits it needs to determine the essential criteria for the particular position. Once determined the essential criteria form the basis for reviewing applications for appointment including the credentials an applicant needs to possess. Once the organisation has established the essential criteria for a position applications can be considered, credentials verified and the scope of clinical practice determined.<sup>48</sup> The Australian Council for Safety and Quality in Health Care *Standard for Credentialing and Defining the Scope of Clinical Practice* (2004) provides guidelines on establishing criteria, collecting information, verifying and assessing the credentials of medical practitioners<sup>49</sup>.

Building on the National Standard, the Victorian Department of Human Services has formulated a consistent approach for Credentialing and defining the scope of clinical practice to be implemented in all Victorian public rural health services. In addition to the recommendations of the National Standard, rural health services will have:

- Direct access to the support of an appropriately skilled Director of Medical Services (DMS). As a general guide, it would be appropriate for all rural health services to have DMS support for a minimum of 25 days per year. For some rural health services this will be a part-time arrangement, possibly shared between services.
- Application forms for Credentialing and privileging (defining the scope of clinical practice), which contain, as a minimum, all the information set out in the model application forms. Three forms are provided, the first for the initial appointment of general practitioners practising in rural settings, the second for the initial appointment of specialist medical practitioners and the third for the re-appointment for both general and specialist practitioners.

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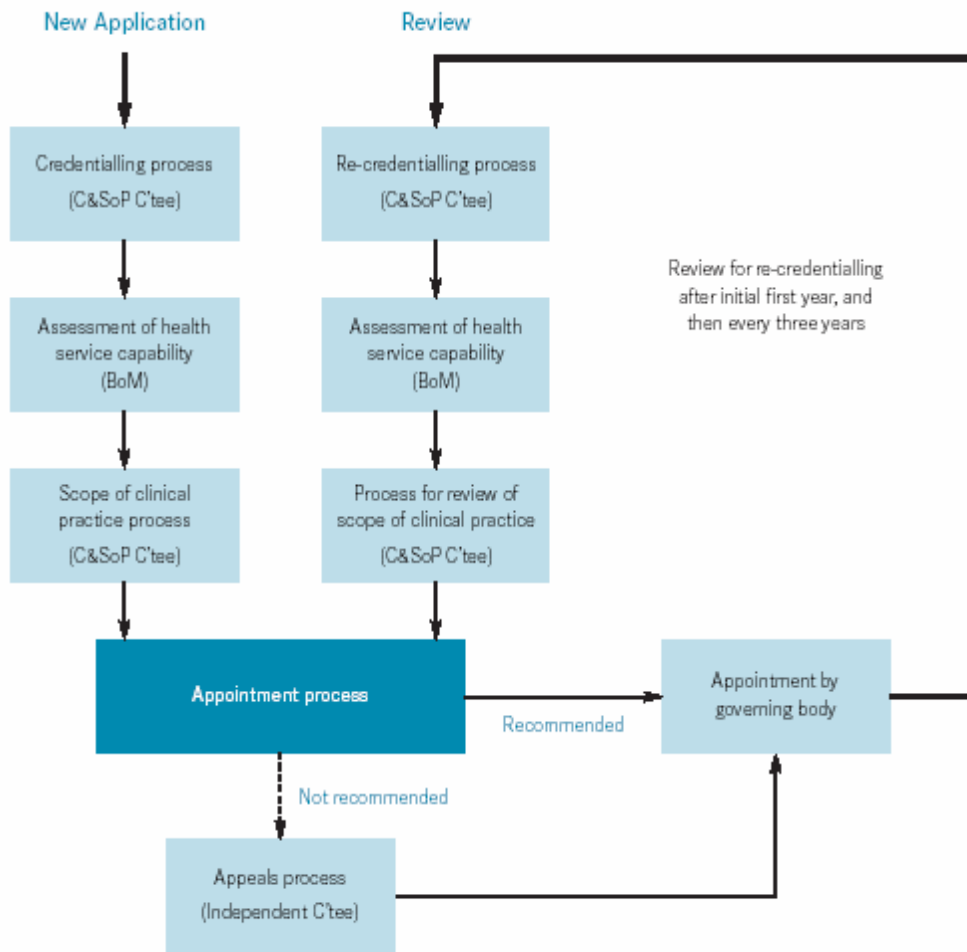
<sup>47</sup> Department of Human Services Policy and Strategic Projects Division *Regulation of the health Professions in Victoria A Discussion Paper*. October 2003 p60

<sup>48</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 p 35

<sup>49</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 pp 35-42

The National Standard highlights the contribution of professional peers. The Victorian policy<sup>50</sup> notes that oversight of an appropriately skilled and qualified medical manager (DMS) is essential for the overall management of medical staff and for ensuring that systems for Credentialing and defining scope of clinical practice are effective. As DMS have a pivotal role in the management of the process for Credentialing and defining the scope of practice, they must have the requisite qualifications, skills and knowledge to complete this task. As a general guide, it is expected that part-time DMS will be appointed for a minimum of 25 days a year for each rural health service. A number of rural health services may share a DMS within a sub-regional grouping. Shared appointments should allow DMS to develop an understanding of the local population's health needs and assist in facilitating Credentialing and defining scope of practice processes across a geographic area.

*Credentialing and Defining the Scope of Clinical Practice Flowchart*



Source: DHS *Credentialing and Privileging (defining the scope of clinical practice) for Medical Practitioners in Victorian Rural Health Services – a Policy Handbook* March 2006

The Victorian rural health services policy requires credentialing and defining the scope of clinical practice to occur before appointments and on an ongoing basis at least once in every three year period. All services must establish committees responsible for the process. Boards of

<sup>50</sup> DHS *Credentialing and Privileging (defining the scope of clinical practice) for Medical Practitioners in Victorian Rural Health Services – a Policy Handbook* March 2006 p7

Management are responsible for medical appointments and it is proposed that the term of appointment and the process of re-Credentialing coincide. Annual performance appraisal processes, the supervision of junior staff and the credentialing and definition of scope of clinical practice on the introduction of new services, procedures or interventions are also required. Medical practitioners are expected to participate in continuing education that is documented and to contribute to the credentialing and defining the scope of clinical practice processes.

### Revalidation and Appraisal

The Western Australian Department of Health (2003) *Credentialing: An Introduction* paper emphasises that "For clinical staff, however, credentialing is valueless without regular revalidation and appraisal"<sup>51</sup> Possessing expert knowledge and skills is seen as meaningless unless these are applied consistently and appropriately and in a sympathetic manner to benefit patients. Appraisal is considered to help practitioners prepare for revalidation by reviewing local clinical outcomes and planning their own professional development.

## 6. Defining the Scope of Clinical Practice

Defining the scope of clinical practice requires a common framework that identifies levels and differences in practice as well as a process for defining the scope of practice for an individual.

Establishing the framework within which to define the scope of practice involves the professional associations and reflects the initial training and registration requirements as well as the ongoing professional development undertaken either independently or to meet sub-specialty and professional accreditation requirements.

Establishing the framework requires identification of the discipline. As noted in the literature, in some areas such as counselling, "the continued growth of a profession requires attention to the issue of whether counseling is a single discipline with specializations or a federation of separate disciplines using similar knowledge, skills and research"

It is widely noted in the literature that defining the scope of clinical practice is specific to an organization and involves delineating the extent of an individual medical practitioner's clinical practice within a particular organisation based on the individual's credentials, competence, performance and professional suitability, and is conducted in the context of the needs and capabilities of the particular organization and the community it serves.<sup>52</sup>

Community satisfaction with the safety and quality of health care depends on a range of parameters and what may be acceptable to a community in one setting may be completely unacceptable in another. There are many factors that will contribute to defining the scope of clinical practice for a medical practitioner. "For example, the assessment of competing priorities for the provision of health resources; the scant data available upon which to make health planning decisions; the potential for health care services to be required on an emergency basis; community preference for local service delivery; the availability of alternative health care services within a reasonable geographic distance; the need to provide an integrated health care service to a particular community; and the need for specific support services to be available to sustain core health care services within a particular environment are all important considerations."<sup>53</sup>

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<sup>51</sup> Western Australian Department of Health (2003) *Credentialing: An Introduction* p 6

<sup>52</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 pp 45-46

<sup>53</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 pp 45

The process of defining a practitioner's scope of clinical practice is, however, described in the literature as organization specific. In some circumstances an organisation may determine that local needs and circumstances justify service provision by non-accredited or endorsed medical practitioners; or, alternatively, an organisation may be unable to provide the necessary support to enable the safe provision of specific clinical services, procedures or other interventions by accredited medical.<sup>54</sup>

*Credentialing and Privileging (defining the scope of clinical practice) for Medical Practitioners in Victorian Rural Health Services – a Policy Handbook* suggests that several health services could establish a sub-regional or regional committee, to undertake Credentialing for all the member health services. However, defining the scope of clinical practice will require appropriate representation on the committee from each health service so that local knowledge determines health service capability to support the scope of practice.<sup>55</sup>

The Australian Council for Safety and Quality in Health Care *Standard for Credentialing and Defining the Scope of Clinical Practice* outlines various approaches to defining the Scope of Clinical Practice: checklists, categorisation, descriptive or a combination and provides detailed guidelines for organisations.<sup>56</sup> Guidelines are also provided on the process for the suspension of a medical practitioner's right to practice, review and appeal processes. Natural justice requires the establishment of an appeals body that is independent of the committee responsible for Credentialing and defining the scope of clinical practice. In all cases this body should advise the governing body directly.<sup>57</sup>

The DHS *Credentialing and Privileging (defining the scope of clinical practice) for Medical Practitioners in Victorian Rural Health Services – a Policy Handbook* notes that consultation with the specialist colleges and other relevant medical organisations will be undertaken to determine core competencies of medical practitioners in rural settings.<sup>58</sup>

The Australian Council for Safety and Quality in Health Care *Standard for Credentialing and Defining the Scope of Clinical Practice* also notes the need to evaluate the safety of new clinical services, procedures or other interventions, and their potential to improve patient outcomes.<sup>59</sup> Some organisations convene standing or *ad hoc* committees to oversee the evaluation of proposed new clinical services, procedures or other interventions. In other organisations, this task may be performed by the committee responsible for Credentialing and defining the scope of clinical practice. In general, requests for Credentialing and defining the scope of clinical practice in relation to new clinical services, procedures or other interventions should not be considered by the committee responsible for Credentialing and defining the scope of clinical practice until they have been assessed in relation to their safety, efficacy and role, and potential financial and operational implications.

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<sup>54</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* 2004 pp 46

<sup>55</sup> DHS *Credentialing and Privileging (defining the scope of clinical practice) for Medical Practitioners in Victorian Rural Health Services – a Policy Handbook* March 2006 p8

<sup>56</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* pp46-47

<sup>57</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* p 18

<sup>58</sup> DHS *Credentialing and Privileging (defining the scope of clinical practice) for Medical Practitioners in Victorian Rural Health Services – a Policy Handbook* March 2006 p8

<sup>59</sup> Australian Council for Safety and Quality in Health Care. *Standard for Credentialing and Defining the Scope of Clinical Practice* p 65

## 7. Structure, Process and Implementation

### Organisations and Professions

Organizations have clinical governance responsibilities and requirements and so do professional bodies that represent and regulate clinical practitioners. Any structure or process for Credentialing and defining the scope of practice has to bring these two elements together.

As Boards have the responsibility for clinical governance it has been argued in the literature that a “common credentialing and privileging for all of the providers in a health care organization facilitates the deliver of a common standard of care” particularly when integrated service systems may involve one practitioner practicing across a number of different sites and services<sup>60</sup>.

The same article in an American nursing journal proposed that the more established medical staff Credentialing and ‘privileging’ structures could provide a foundation for creating a system that includes other clinicians.<sup>61</sup> It is suggested that a multi-disciplinary credentialing committee would ensure that standards and common processes were implemented across all areas of an organization and this could be extended across all health services within a region. Clinicians would be subject to the same requirements and then, with permission, all the credentialing data could be entered once, held centrally, transmitted electronically to different practice sites and updated as required. However, centralised processes for defining the scope of practice were considered to face significant barriers.<sup>62</sup>

### Process

An article on the lessons learned from the credentialing of health educators in the United States<sup>63</sup> identified the following five basic lessons learned:

1. Profession-wide input into the development of credentialing process is critical for profession-wide ownership and support.
2. Communication with key stakeholders is essential throughout the development process.
3. Credentialing must be based on competencies linked to job responsibilities
4. An independent credentialing organisation is essential with a viable plan for short term and long term funding.
5. Research must be conducted on the outcomes of credentialing and include unintended impacts as well as benefits.

The issue of “ whether the presumed benefits of credentialing justify the strenuous effort that will be necessary to develop and implement it” is discussed in the America literature on public health practitioners<sup>64</sup> and is linked to an ability to demonstrating skills and experience required.

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<sup>60</sup> Lumb, E W. Oskvig, R M. “Multi-disciplinary Credentialing and Privileging: A Unified Approach” *Journal of Nursing Care Quality*; April 1998; 12. 4 pg 37

<sup>61</sup> Lumb, E W. Oskvig, R M. “Multi-disciplinary Credentialing and Privileging: A Unified Approach” *Journal of Nursing Care Quality*; April 1998; 12. 4 pg 37

<sup>62</sup> Lumb, E W. Oskvig, R M. “Multi-disciplinary Credentialing and Privileging: A Unified Approach” *Journal of Nursing Care Quality*; April 1998; 12. 4 pg 41

<sup>63</sup> Livingood, W C. & Auld, M E “The Credentialing of a Population –based health profession: Lessons Learned from health Education Certification” *Journal of Public Health Management Practice* 2001 7(4), p43

<sup>64</sup> Akhter, M N “Professionalising the Public Health Workforce: the Case for Certification” *Journal of Public Health management* 2001, 7(4) , p49

## Cost

The high cost of credentialing and re-credentialing in the United States, where health care providers are credentialed at each new facility, is well recognized.<sup>65</sup> However the barriers to the creation of a common system for credentialing health care providers have been identified<sup>66</sup> as political (particularly encroaching on the role of medical practitioners), regulatory (variations across states) and terminological (confusion of terms such as credentialed, accredited).

In an article on the value of certification of operating room nurses in the United States, cost was perceived as the greatest barrier to certification together with lack of compensation for certification in the form of increased salary.<sup>67</sup>

## 8. Matters of Interest

### International Council of Nurses Credentialing Forum 2003

Reports from nine countries (Australia, Canada, Denmark, Japan, Ireland, UK, New Zealand, Taiwan, Jamaica) were analysed, key issues and priorities identified and the reports summarised.<sup>68</sup> The diversity in approaches to credentialing and the differences in emphasis between countries is evident from the reports however, there were many common issues. Issues and trends identified in the regulatory environment include:

- Development of national systems for credentialing is slow, tenuous and with many difficulties but may be seen as a preferred way forward.
- Most countries are currently working actively on continuing education and credentialing of Nurse Practitioners and nurses in specialist or advanced practice.
- Countries are experiencing ongoing health reform with accompanying legislative changes and increasing financial pressures.
- Regulation of education and registration for training as a nurse is more standardised and comparable across countries although there are changes in entry level with widening and lowering of the entry gate in some countries and increased opportunities for higher level specialist education.
- Regulation of post-graduate nursing or continuing education is different across countries; it may be by local or national arrangement or by associations, national nursing organisations or government or regulatory bodies. Some specialist groups are seeking international accreditation.
- There is increasing emphasis on competency based education and assessment.
- National nurses associations are collaborating with other associations and regulatory bodies or multi-disciplinary agencies in relation to credentialing. The number and variety of agencies involved in the credentialing process varies across countries.
- Increased interest among education providers in having their programs accredited; increased interest in the accreditation of individuals, health service providers and workplaces; and emphasis on the contribution of credentialing and accreditation to quality standards and care.
- Changing emphasis in the roles of Regulatory Bodies, e.g. increased role in standard setting and competency assurance; reduced focus on advocacy and enhancement of the

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<sup>65</sup> FitzHarris, J B. "Challenges of Including Dietitians, Nurses, Occupational Therapists, and Pharmacists in the Federal Credentialing Program" *Military Medicine* 165, 10; Health & Medical Complete p 716

<sup>66</sup> FitzHarris, J B. "Challenges of Including Dietitians, Nurses, Occupational Therapists, and Pharmacists in the Federal Credentialing Program" *Military Medicine* 165, 10; Health & Medical Complete p 718

<sup>67</sup> Byrne, M. Valentine, W Carter, S. "The Value of Certification-A research Journey" *Association of Operating Room Nurses. ACRN Journal*; Apr 2004; 79, 4; Academic research Library p 834

<sup>68</sup> Kennedy, A Summary of County Reports, International Council of Nurses Credentialing Forum p2

- profession in some jurisdictions; reduced role in accreditation of nursing programs; potential loss of statutory powers and independence.
- Legislative changes to govern all health professions rather than separate professional groups and increased lay participation in regulatory bodies.

The summary of Country Reports from the International Council of Nurses Credentialing Forum in 2003<sup>69</sup> noted that the Royal College of Nursing, Australia had undertaken a feasibility study that supported a national approach to credentialing and that:

*The feasibility study reported that a majority of both nurses and employers supported a mechanism for credentialing. These groups see it as supporting higher standards of care, monitoring of performance, portability of qualifications, consumer confidence and a recognition of qualifications.*

*A number of speciality groups have credentialing for members, e.g. critical care, gastro-enterology and community midwives. Some nurse specialist groups have sought international credentialing, e.g. diabetic nurses, respiratory nurses and stoma therapists because there is no process in Australia for credentialing or they would prefer an international credential.*

*A Credentialing for Practice Programme has been undertaken by the Australian and New Zealand College of Mental Health, in partnership with the Tasmanian Nurses' Board.*

The report further notes that:

*The RCN Australia argued for the inclusion of the nursing profession in the development of a national standard for credentialing and clinical privileges for the medical practitioner. Although the approach in the credentialing clinical privileges of medical practitioners is not deemed appropriate to nurses, there may be some components of this process which could be adapted to nurses. This development is being undertaken by the Australian Council on Safety and Quality in Health Care (ACSQHC).*

### **Australian Health Promotion Practitioners Survey**

Inspired by the credentialing of health educators in the United States, that “ provides a framework that helps establish minimum standards of best practice as well as a structure whereby certain skills can be acquired and monitored”<sup>70</sup> a study was undertaken to investigate attitudes towards the credentialing of a section of the health promotion workforce. The majority of respondents (367) agreed or strongly agreed with the need for some form of credentialing identifying the greatest benefits as accountability for professional standards and to the professional standing and recognition of health promotion practitioners. Criteria for credentialing most strongly supported were a tertiary degree or post graduate diploma and ongoing professional development, competency based examinations were not well supported.<sup>71</sup> Credentialing was seen as a mechanism to ascertain the knowledge, values and skills required by health promotion practitioners and determine the degree to which these competencies were achieved or maintained over time.

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<sup>69</sup> Kennedy, A Summary of County Reports, International Council of Nurses Credentialing Forum p4

<sup>70</sup> Redman J & O'Hara “Perceptions of Credentialing for Health Promotion Practitioners in Australia” *Health Promotion Journal of Australia* 2003: 14 (1) pp25

<sup>71</sup> Redman J & O'Hara “Perceptions of Credentialing for Health Promotion Practitioners in Australia” *Health Promotion Journal of Australia* 2003: 14 (1) p29

## NSW Midwives

NSW Health Department issued a policy directive<sup>72</sup> in August 2005 that required Area Health Services to ensure that midwives working in midwifery-managed models of care are credentialled. This is to optimize the quality and safety of maternity care through the provision of a skilled and competent midwifery workforce. Compliance is mandatory. The NSW Health Credentialing Framework seeks to optimise the quality and safety of maternity care through the provision of a skilled and competent midwifery workforce to work in service models of care that provide continuity of care and models which are midwifery managed.

The New South Wales Midwives Association (NSWMA), a branch of the Australian College of Midwives (ACMI), will administer the credentialing framework.

Credentialing is described as a key component of professional governance where members of the profession set standards and establish the requirements for entry into the profession as well as the maintenance of that recognition and standard of practice. This is expressed at an individual practitioner level to:

- Improve professional accountability, transparency and autonomy
- Focus on evidence-based practice and health outcomes
- Commit to ongoing education and practice development
- Safeguard quality in health care delivery
- Uphold standards of the profession and ethical practice
- Protect human rights and choices
- Maintain public trust and confidence

The Credentialing process is designed for midwives to individually assess their own needs and practice standards, identify which areas require additional attention, and when ready, seek to be formally credentialled. The credentialing process involves four steps:

- Self Assessment
- Panel Review
- Workstation assessment
- Scenario based assessment

## Australian Cancer Clinicians

The Australian Cancer Network (CAN) Credentialing Steering Committee has developed resources to increase understanding of the process of effective Credentialing of Cancer Clinicians and has provided advice and supervision for a project to produce practical information and guidance for clinicians and managers.

Based on the National Standards, two reports were produced for the Australian Cancer Network by the Sydney Health Projects Group of the University of Sydney lead by Professor Michael Frommer and were the first examples of customisation of the national standard in order to focus on a particular and complex segment of the health system – namely cancer services.

The first of these reports, "The Credentialing of cancer clinicians in Australia" (August 2005) describes important aspects of Credentialing and defining the scope of practice and interprets the National Standard for Cancer Service Clinicians. The second report, the appendix, "Credentialing of cancer clinicians: A guide for Australian health-care organisations" is essentially a "how to do it" template setting out sixteen practical steps to be followed when developing and implementing a local cancer Credentialing system.

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<sup>72</sup> NSW Health Policy Directive *Midwives – NSW Health – Credentialing Framework*. August 2005

### American Advanced Nursing Practice

Defining the scope of practice can expand or limit professional practice. An article in the Internet Journal of Advanced Nursing Practice<sup>73</sup> argues that a broader definition of the scope of nursing practice would enable expansion of primary care services to better serve the health care needs. It notes that Nurse Practitioners in the United States are uniquely qualified with advanced practice skills to meet the increased demand for primary care services yet restrictive practice environments continue to limit their efficient use both nationally and internationally. While registered nurses are legally authorized to provide services for primary health promotion, disease prevention, and assessment of health status, questions remain as to the degree of independence, prescriptive authority, and reimbursement for services. The paper describes the current scope of practice, clinical competencies, and practice settings while tracing the historical development of this type of advanced practice nurse.<sup>74</sup>

### Practice Development Credentialing in the United Kingdom

A journal article on Practice Development in the United Kingdom<sup>75</sup> describes the purpose, process and value of an international Practice Development Program by which clinical units can choose to be credentialed.

Fourteen Credentialing criteria encourage a contemporary decentralised approach to management and leadership practices where responsibility, authority and accountability are locally owned through articulated expectations at all levels of the organisation. As the primary aim of the Practice Development Program is to achieve quality patient care through determining best practice, it is only achievable if the unit team is functioning effectively from the start and the unit has effective leadership.

The concept includes the multi-disciplinary team, cross boundary agencies and service users. The policy goal is to incorporate these diverse groups to address a wider remit that emphasises a collective responsibility for the quality of patient care, and encourages the sharing of best practice. The process leading to Credentialing is voluntary. The Practice Development Program provides a comprehensive framework, which facilitates innovation, leadership, creativity, evaluation and measurement of clinical outcomes and leading edge practice within existing resources.

### American Health Educators Diabetes Educators

In the United States Credentialing and defining the scope of clinical practice have been linked to defining qualifications/training, expanding the role of the practitioner and reimbursement. For instance, diabetes educators are recognized as essential providers of diabetes care. Health education and diabetes education are recognised as expanding and evolving fields and credentialing examinations, standards, and scopes of practice for health educators have been implemented<sup>76</sup>. In order to meet the needs of all individuals who require health education in the prevention and treatment of disease, health educators are recognized and accepted from a variety of disciplines. The role of diabetes educator can be assumed by various health care professionals, including but not limited to nurses, physicians, dietitians, social workers, podiatrists, exercise physiologists, and pharmacists. The American Association of Diabetes

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<sup>73</sup> Sherwood GD, Brown M, Fay V, Wardell D: Defining Nurse Practitioner Scope of Practice: Expanding Primary Care Services. *The Internet Journal of Advanced Nursing Practice*. 1997. Volume 1 Number 2.p1

<sup>74</sup> Sherwood GD, Brown M, Fay V, Wardell D: Defining Nurse Practitioner Scope of Practice: Expanding Primary Care Services. *The Internet Journal of Advanced Nursing Practice*. 1997. Volume 1 Number 2.p1

<sup>75</sup> Chin, H & Mc Nichol, E "Practice Development Credentialing in the United Kingdom: A Unique Framework for Providing Excellence, Accountability and Quality in Nursing and Healthcare" 2000 *Online Journal of Issues in Nursing* Vol5, No 2, manuscript 5

<sup>76</sup> Siminerio L M, Defining the Role of the Health Education Specialist in the United States *Diabetes Spectrum* Volume 12 Number 3, 1999, Page 152

Educators (AADE) established the Scope of Practice for Diabetes Educators and the Standards of Practice for Diabetes Educators.

The American Scope of Practice and Standards documents provide a framework of seven responsibilities and competencies for entry-level health educators for health care professionals who teach people with diabetes. Increasingly, the scope of practice for diabetes has expanded to involve advanced practice roles that may have been previously considered to be medical management. However, the article argues that to substantiate the role of the health educator in practice and obtain *reimbursement* for services, further work and acceptance of clearly defined responsibilities and outcome data is required<sup>77</sup>.

## 9. Tools

An appendix to the NHS Integrated Governance Handbook provides a ready reckoner self assessment tools for boards to gauge their progress in greater integration of governance activities, there is also an online tool to help Chairs review their own performance and that of their Boards as a whole. There are a number of self-assessment tools available that monitor the performance of not-for-profit Boards.

Based on the National Standard the Victorian policy provides a number of tools:

**Appendix 1** provides a checklist for the credentialing and defining the scope of clinical practice process and appointment, based on the National Standard.

**Appendix 2** provides a flow chart for the Credentialing, defining the scope of clinical practice and appointment process.

**Appendix 3** sets out the core information required in the model application forms for general practitioners and for specialists working in rural health services.

**Appendix 4** sets out the core information required in the model re-application forms for general practitioners and for specialists working in rural health services.

**Appendix 5** is a template Referee Report Form

**Appendix 6** describes the requirements for a Credentialing and defining scope of clinical practice committee – terms of reference and Membership

Many health services such as Dental Services Victoria and Southern Health, have developed or are implementing credentialing programs and related relevant human resource management practices and consequently have forms and procedures relevant to the process of credentialing and defining the scope of practice.

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<sup>77</sup> Siminerio L M, Defining the Role of the Health Education Specialist in the United States *Diabetes Spectrum* Volume 12 Number 3, 1999, Page 157

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## 11. Industry Bodies

### **QIC—Quality Improvement Council**

QIC is a national primary health industry body that produces standards for primary health care and associated services. The QIC Review and Accreditation Program is based on the QIC standards, but has the capacity to use service delivery standards developed by other industries provided they meet particular criteria. These criteria include consistency with QIC's Core Concepts based on the social model of health.

### **QICSA—Quality Improvement and Community Services Accreditation**

QICSA provides accreditation services in Victoria under licence from the Quality Improvement Council (QIC).

**ACHS The Australian Council of Healthcare Standards** is an independent, not for profit organisation whose mission is to promote continuing improvement in the quality of care delivered by health care organisations.

**The Australian Council for Safety and Quality in Health Care.** Established in January 2000 by the Australian Government Health Minister with the support of all Australian Health Ministers to lead national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error.

**Australian Commission on Safety and Quality in Health Care.** The Commission replaced the Australian Council for Safety and Quality in Health Care on 1 January 2006. Over its life, the Commission will:

- Lead and coordinate improvements in safety and quality in health care in Australia by identifying issues and policy directions, and recommending priorities for action
- Disseminate knowledge and advocate for safety and quality
- Report publicly on the state of safety and quality including performance against national standards
- Recommend national data sets for safety and quality, working within current multilateral governmental arrangements for data development, standards, collection and reporting
- Provide strategic advice to Health Ministers on best practice thinking to drive quality improvement, including implementation of strategies and
- Recommend nationally agreed standards for safety and quality improvement.

The Commission has been funded by the Australian, State and Territory Governments to develop a national strategic framework and associated work program that will guide its efforts in improving safety and quality across the health care system in Australia.

**VCQ Victorian Quality Council** The Victorian Quality Council is responsible for fostering better quality health services in Victoria by working with stakeholders to develop useful tools and strategies to improve health service safety and quality. Strategic goal 1 is to support governance and leadership in healthcare organisations to develop a culture of quality and safety improvement by: engaging and educating boards, managers, clinicians, consumers and other stakeholders; and encouraging, valuing and utilising consumer participation.

## 12. Other references

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