
Credentialing and Defining the Scope of Practice in Community Health EMR Project

Final Report

December 2006



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Executive Summary

This is the final report of a project established to determine a model of practice that will support and systematically develop the process of Credentialing and defining the scope of practice in community health services. The Eastern Metropolitan Region Project Governance Group oversaw the project liaising with the VHA/CHV (Victorian Healthcare Association/Community Health Victoria) Clinical Governance Steering Group.

Credentialing and defining the scope of clinical practice aim to ensure that practitioners in any setting provide high quality services consistent with good practice and expected client benefits. It seeks to ensure that quality services are provided appropriately and safely across community health programs in a time of change. A key part of any clinical governance framework, Credentialing and defining the scope of practice underpin good service delivery.

Credentialing and defining the scope of practice is already undertaken by some community health services and it is acknowledged that some sound practice currently exists. However work needs to be done to ensure a consistent statewide approach and to identify resources over a period of time to support Credentialing and scope of practice. The introduction of a standard approach is timely as it will build the capacity of the community health sector to respond to current and future pressures by promoting workforce retention, considering opportunities for innovative practice, developing clinical governance frameworks and improving service quality. As the community health sectors role in the provision of ambulatory care services and integrated care is expanding it is an ideal time to address these issues and to build the capability of services.

The **recommendations can be summarised** as follows:

1. That the findings of the EMR project on Credentialing and Defining the Scope of Practice be **disseminated across the community health sector** (in collaboration with the VHA/CHV Clinical Governance Steering Committee) and that consultations be held to gather feedback and further a shared understanding of this initiative.
2. That consideration be given to establishing **Clinical Supervision/Leadership** within the Community Health sector and that this is progressed through a project with support from DHS and VHA/CHV.
3. That work be undertaken in collaboration with professional bodies and registration boards to develop a statewide **framework for defining the scope of practice** for disciplines within Community Health starting with Counselling and Occupational Therapy.

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4. That the **tools** developed during this project are trialled as part of the work of the Clinical Governance Steering group.
5. That the **professional bodies** governing staff involved in providing clinical services to community health clients be informed of the findings of this project and given an opportunity to comment on the final report and contribute to the development of Credentialing and defining the scope of practice in community health.
6. That the **Human Resource function within the Community Health sector** is assessed as to its capacity to undertake this initiative and to identifying new approaches and personnel structures that may be able to contribute to the resourcing of this initiative.
7. That a **pilot** be conducted to test, scope, cost and further develop a model and structure of Credentialing and Defining the Scope of Practice in Community Health within the catchment of the Outer East PCP. In establishing an appropriate structure the pilot should explore the possibilities for a “whole of health “ approach and identify a lead agency ensuring it has the infrastructure to support a major pilot project.
8. That the **Primary Health, Quality and Safety and the Workforce Development Branch of the Department of Human Services** together with the existing VHA/CHV Clinical Governance Steering Group, contribute to the ongoing planning and development of Credentialing and defining the scope of practice in community health across the state and monitor the piloting of these recommendations. A nominated principal contact in DHS (Primary Health Branch) is required who carries responsibility for the further development of this work and the proposed pilot of the guidelines and tools developed by this project.

The **resourcing** of this initiative is a critical factor primarily because stand alone community health services and the primary care sector as a whole are relatively under resourced to support a comprehensive approach to Credentialing and defining the scope of clinical practice. In particular, the management and administrative structures within community health services are minimal and have limited ability to absorb new initiatives that require human resources. The proposed ‘Care In Your Community’ initiative provides an opportunity for community health services to build the capacity required for more comprehensive approaches.

Implementation and evaluation of the proposed pilot of the preferred structure and the associated guideline and tools will require resources. It will also assist in identifying any future resources that may be required to fully implement credentialing, re -Credentialing and defining the scope of practice in community health and explore how these could be obtained and shared.

The guidelines and tools developed in the course of this project support new structures that include a Credentialing committee that has responsibility for the development and review of structures and

processes for Credentialing and defining the scope of practice. These committees cover a defined catchment, which extends beyond the boundaries of a single community health service. Policies and tools are being developed by VHA/CHV to develop existing practices within community health services. Consultation with stakeholders in other DHS regions when the guidelines are trialled will assist in identifying any regional differences that could impact on the proposed model.

Implementation planning is essential. Establishing consistent Credentialing and defining the scope of clinical practice in community health is complicated. Many disciplines are involved as well as roles for which there is no specific discipline such as case managers and allied health assistants. A large number of staff need to be credentialled, many of whom are part time with high turnover rates. The service structures are variable and include some very small organisations. Establishing statewide scope of practice frameworks for each profession is also a significant challenge.

The implementation plan should reflect the availability of resources and incremental introduction may be required in the absence of appropriate resources. For example, this may mean that community health services commit to some basic but non negotiable required components in the first stage such as requiring staff to be registered (if applicable) or a member of their professional body and to undertake police and referee checks as part of the appointment process. It is important however, to continue to undertake the groundwork for the introduction of new structures by improving and standardising existing processes including access to clinical supervision.

1. The Project

Project Governance Group

As part of good governance and an appreciation of the importance of clinical governance, a project was proposed to develop a standard approach to 'Credentialing and Defining the Scope of Practice in Community Health'. LIME Management Group were engaged to conduct a project managed by Knox Community Health Service and funded by the Eastern Region of DHS. A Project Governance Group was drawn from the Eastern Metropolitan Region (EMR) and chaired by Anne Lyon, Chief Executive Officer of Knox Community Health Service.

The project acknowledges the enthusiastic support and guidance of members of the Project Governance Group and the consultants have appreciated highly the input from the Project Manager. Appreciation also to Dr Shane McGuire, Manager, Quality and Clinical Compliance, Health Purchasing and Provider Relations, Dental Health Services Victoria who provided editorial input to the final report.

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Others who attended the workshop:

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Aims and Objectives

Credentialing and the scope of clinical practice are growing aspects of the broader work on clinical governance and quality in the health sector and support the development of good governance in the community health sector.

The project brief stated that the objective of the EMR project on Credentialing and defining the scope of clinical practice “is to ensure that practitioners in any setting provide high quality and safe services consistent with good practice and expected client benefits by:

- Developing a potential **structure and process** for Credentialing and defining the scope of clinical practice to support safe and quality service provision.
- Developing **guidelines and or tools** to support Credentialing and defining the scope of clinical practice across the Community Health Sector.”

Process

The LIME Management Consulting Group was engaged in July 2006. The project was undertaken in four main stages: planning; information collection and analysis including a literature review; the development of a preferred model and lastly, the preparation of draft guidelines and tools including consideration of implementation issues. The first meeting of the Project Governance Group was held on the 8th August, the workshop on the 19th September and a final meeting held on the 16th October.

Links were made with the Clinical Governance Steering Group of Community Health Victoria, a Council of the Victorian Health Care Association (VHA/CHV), in particular with Alison Brown the Project Worker for the Scope of Practice and Credentialing Working Group. A number of members of the Project Governance Group were also members of the VHA/CHV Working Group. Clare Byrne, the Project Worker for Credentialing in Primary Care at Southern Health, provided valuable assistance, as did a number of other people working in this area within the Department of Human Services and elsewhere.

The aim of the workshop was to report on project progress, consider the Literature Review, identify the principles guiding these reforms, review the options for the structures, guidelines and tools, as well as to develop a vision of how it would work in practice, identify the challenges and determine how they might be addressed.

Outcomes

A number of key documents, attached as appendices, were produced in the course of this project including: the literature review, information lists on professional associations and registration requirements, as well as the guidelines and tools including:

- A checklist for services implementing Credentialing, defining the scope of clinical practice
- Draft application forms for Credentialing and re-Credentialing in community health
- Draft Terms of Reference for a Credentialing and Scope of Practice Committee.

The project was an excellent way for the people involved to share their knowledge and to gain a better understanding of what Credentialing and defining the scope of practice in community health might involve.

A number of other documents were produced that are available on request from VHA, and include:

- The Report of the EMR Workshop on Credentialing and Defining the Scope of Practice held on the 19th September 2006
- A Background Paper on Clinical Supervision. This was developed with reference to the findings of a Southern Health literature review and paper on supervision and the “EMR Guidelines for Supervision in Community Health Counselling Discussion Paper”.
- A Background Paper on the Registration of Health Professionals.

2. Background

Key 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 is “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 improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”.¹ Clinical governance provides a way of ensuring that quality improvement and safety systems are in place throughout a health service, at every level.²

Registration Professional registration determined by a registering authority that determines the criteria for entry to a professional body, sets, upholds and enforces standards of practice (including codes of conduct and ethics) and identifies 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 environments.³

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

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

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

Defining the scope of clinical practice follows on from Credentialing and involves delineating the extent of an individual health 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 practitioner’s scope of clinical practice.⁴

The term “clinical privileging” is sometimes used as an alternative to the term “defining the scope of clinical practice”, especially in relation to medical practitioners.

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 professional body.

Context

There are a number of drivers of the development of Credentialing and defining the scope of practice some of which are outlined in greater depth in the Guidelines provided as **Appendix 3**. These include:

- The National Standard developed by the Australian Council for Safety and Quality in Health Care published in 2004 and more recently, the Credentialing and Privileging for Medical Practitioners in Rural Victoria Policy Handbook 2006; both these documents were subject to extensive consultation and took a number of years to develop and implement. They have provided a basis for the work in the community health sector.
- The Patel case in Bundaberg Queensland and the subsequent Queensland Public Hospital Commission of Inquiry in 2005 which served to reinforce the importance of ensuring health agencies adopt the National Standards.
- The extension of the role of community health services through an increased emphasis on ambulatory and primary care services as an important element of an integrated, affordable and effective health care system able to meet the needs of an ageing population and people with chronic illnesses. Community health services are being asked to take up greater responsibilities and this leads to ensuring that the lines of accountability are clear to other service providers and the community.
- An increasing emphasis by Government on good governance and quality systems⁵ in community health. Even without this policy emphasis, there is a growing interest from all stakeholders in achieving best practice in the provision of community health services.

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

⁵ The Victorian Quality Council, *Better Quality, Better Health Care, A Safety and Quality Improvement Framework for Victorian Health Services* 2003

Literature review

A literature review was undertaken in the first stage of the project that focused on material relevant to the application of Credentialing and the scope of clinical practice to community health settings. The background section of this review outlined issues related to the broader governance context and the section on matters of interest covered recent developments in the practice and application of approaches to Credentialing and defining the scope of practice.

The literature was sourced by the members of the VHA/CHV Clinical Governance in Community Health Steering Group and the Governance Group of the Project on Credentialing and Defining the Scope of Practice in EMR. The material supplied was then supplemented with selected documents identified by LIME Group consultants.

Points of interest in the literature review include:

- The definitions of terms are useful but there is also a need to develop a shared understanding of what the various words mean in practice.
- The literature clearly suggests that Credentialing and Defining the Scope of Practice should be integrated with both governance and quality systems.
- The duty of quality is shifting from individual practitioners to organisations and boards ensuring that staff are committed and supported to develop best practice and a culture that values quality.
- Clinical leadership is identified in the literature as a critical pre-requisite to Credentialing and Defining the Scope of Practice.
- Credentialing and Defining the Scope of Practice for medical practitioners in public hospitals differs from the practice in community health services in that the latter is generally less clinical, less risk focused, multi-disciplinary, more focused on the development of staff and best practice, includes more consumer feedback and needs to cope with large number of part time staff.
- Scope of Practice may be defined in a number of ways: as an area of practice, for example types of counselling; as procedures undertaken, for example by dentists; by the type of client for example the young or old, by the type of disease, or a combination of approaches – whatever is relevant for a particular profession. The approach adopted will also reflect the elements of the education and training for each profession.
- The literature highlights the importance of consultation and planned process in achieving practical outcomes that practitioners and professional bodies are committed to implementing.
- Finally, it is clear that the scarce resources in community health must be used carefully and for the most benefit of clients – there is an opportunity cost.

Principles for Reform

As outlined in the attached Guidelines, the principles and values guiding the development of Credentialing and defining the scope of practice in community health include:

Accountability: community health services should be accountable to the community for their decisions and operations; information should be reported to Boards governing community health services. Practitioners should be held accountable for the delivery of effective and high quality services, within an ethical framework that includes commitment to the best interest's of clients and to maximising their control over their own lives.

Consistency: there should be a consistent approach and standard tools for Credentialing and defining the scope of practice across Victorian community health and primary care services, sharing of information and the development of common guidelines.

Effectiveness: the system for Credentialing and defining the scope of practice should be effective in protecting the public from harm and promoting equity of access and the provision of high quality care. This includes a commitment to best practice, quality services and managing risk.

Efficiency: the resources expended and the administrative burden imposed by the model should be sustainable and justifiable in terms of the overall benefit to the community. Information management should be electronic, minimize duplication and maintain privacy and confidentiality.

Consumer Participation: Credentialing and defining the scope of practice should be responsive to client feedback and needs. Mechanisms are required to identify these needs. Quality improvements should seek to improve health outcomes for consumers.

Flexibility: the procedures put in place should be able to respond to emerging issues as the health care system evolves, as the roles and functions of health professionals change and as practitioners develop their skills and experience. It should be family friendly and inclusive of part time staff.

Transparency: the decision-making processes should be open, clear and understandable to both consumers and practitioners. Credentialing and defining the scope of practice in Victorian community health services is seen as a shared responsibility of all stakeholders.

To be effectively implemented these principles should be consciously promoted as an integral aspect of the culture and practice of community health services.

3. Key Issues

Consistency of Practice Across the Community Health Sector

Community health services have their own appointment processes but a common approach will require the development and use of common tools/forms, policies and procedures across the sector.

There is a need to develop the current practices relating to position descriptions, selection and appointment, as these provide the foundations for Credentialing and defining the scope of practice. It is also important to plan for further long-term development and improvements to practice. This will require consultation, support, agreement and education across the sector. The VHA/CHV Credentialing and Scope of Practice Working Group will play a key role in directing and disseminating future development.

Consultation and Collaboration

Proposals for Credentialing and defining the scope of practice should be compatible with other initiatives currently occurring in relation to clinical governance policy, reporting for Boards of Management and risk management. Further training and education of Boards of Management will be required to help develop a shared vision and understanding of all areas of clinical governance.

To avoid duplication of effort it is necessary to integrate Credentialing and defining the scope of practice processes with existing quality monitoring mechanisms and reporting frameworks including those for the ACHS, QICSA and other accreditation organisations.

Lack of Structured Clinical Leadership and Supervision Practices

Unlike the acute sector, in the past the community health services have not generally had clear lines of clinical accountability as part of their organisational structures. Current lines of responsibility are based on program management rather than clinical responsibility; there are no specified clinical leaders and limited career structures. There is increasing awareness across not only the medical and dental professions, but also within other health professions, of the need to manage risks and develop a structure that can provide clinical leadership in a cost effective manner. This creates opportunities for the sharing of clinical expertise and leadership across the primary health sector. It also creates the potential for a “whole of health” approach across an integrated health care system. An increase in the clinical supervision available to community health clinicians will be a significant advance towards implementing best practice. Professional support and professional development provided by designated clinical leaders within allied health disciplines would be of further benefit.

Limited Human Resource Management Capacity

Currently in the community health sector there is limited capacity and infrastructure to perform/support human resource management functions over and above normal recruitment and staff management functions. Program Managers and administrative staff undertake most of the tasks and there are variations in practice. Policies, guidelines and training will be required to improve current practice. Implementation of new structures and processes for Credentialing and defining the scope of practice may require additional dedicated staff. However, it may be possible to share human resource management appointments across a number of smaller community health services provided this occurs in line with required privacy legislative requirements. Ideally there would be an electronic database, a minimum data set and standard frameworks for reporting to Boards and to the Department. Electronic transfer and storage of information is desirable.

Workforce Issues

As each practitioner needs to be credentialled, the high number of part time staff who work in community health together with the shortage of skilled labour, creates additional challenges. Data from five community health services (Knox, Yarra Valley, Inner East, Ranges, Monash Link) in the EMR indicates that 244 practitioners worked an EFT of 146.6 EFT, an average of 0.6 EFT per person. Allied health staff in community health services are generally paid at lower rates and have less opportunity for advancement than their colleagues in the acute sector, consequently the workforce is relatively young, and primarily comprised of women who may take maternity leave and return to the workforce part time. If staff work across several site, Credentialing could apply across these sites thereby decreasing the work load. Privacy again would need to be covered.

Multi-disciplinary Framework

There is a large range of professional clinical disciplines working in community health services and increasingly practitioners are working in multi-disciplinary teams. Frameworks for clinical supervision, clinical leadership and Credentialing must be applicable and if there is not sufficient in-house expertise services need to be able to draw on networks and/or recognised leaders in the field for advice and support. This approach would support the current policy direction for service delivery with a focus on increased community based service delivery and multi-disciplinary teams.

Legal Issues and Consumer participation

While the term 'Credentialing' does not carry a specific legal meaning, Credentialing should help to clarify the legitimate expectations of clients regarding protection from incompetence, safety from harm and receiving the services that agencies claim will be delivered.

Quality and clinical governance frameworks take a proactive approach to risk management and to be both accountable and transparent they must be underpinned by funding and service or partnership

agreements, proper process and record maintenance, and document the liaison with professional bodies. Processes are required that obtain and act on client feedback with a view to improving service systems and assist the Credentialing of practitioners and defining their scope of practice.

Systemic Changes

An ageing population and increasing healthcare costs are creating pressures on government expenditure. At the same time there is increasing awareness that prevention, early intervention, health promotion and a more integrated, wholistic health system can achieve better outcomes. More effective service delivery options are being sought. Australia has both private and public health services; increasingly the ability to 'self insure' or pay for private health insurance can determine timely access to specialist, early intervention and ancillary services. If the traditional community health services are to be an integral part of the expansion of more complex health care services in the community they must have effective clinical governance systems that enable them to offer clinical services, including those for the treatment of chronic and complex needs, to the whole community.

4. Proposed Model

The Catchment

A model for Credentialing and defining the scope of practice in community health services could be applied on a regional or sub-regional area basis depending on the scale of operation of community health services in a particular area and the existing networks. The catchments of Credentialing committees should coincide with those of Primary Care Partnerships where appropriate and could be regional in rural areas. To minimise costs catchments should be as large as possible without creating unreasonable travel costs. Credentialing committees could potentially be a sub-set of those for medical and other practitioners, especially in rural areas.

The Credentialing committee structure proposed in this report is most applicable to stand alone community health services that do not have the resources and expertise to independently develop credentialing committees. However, the guidelines could also apply to integrated acute/primary care services. Either way mechanisms will be needed to share expertise, disseminate the learnings, standardise policies and develop procedures across stand alone community health services with those community health services based in acute networks.

The Components

Credentials verification or certification processes – require a standardised approach across the state for each profession. Community health service program managers currently generally hold responsibility for verifying credentials of applicants and checking references and/or referees. Once established, Credentialing committees will have the responsibility for reviewing the credentials and the status of practitioners recommended for appointment. Once credentials are verified for an individual practitioner, either on appointment or when they apply to be Credentialed, the documentation could be acceptable and transferable between community health services. Verification of qualifications and experience by program managers or Credentialing committees could be done by an agreed process through links with data bases held by some professional bodies.

As part of their Clinical Governance role Boards of Management would ensure that guidelines for verifying credentials of staff were followed as part of the appointment process. The VHA/CHV Credentialing and Scope of Practice Working Group is developing policies to guide this process as it applies to current practices. Once established Credentialing committees will develop practice guidelines that are consistent with the structures within their catchments.

The role of the Credentialing committees for the allied health practitioners in community health services differs to the role of the Credentialing committees for medical practitioners. The former is more focused on systemic development, supporting practitioners and reviewing the scope of practice of appointments made by health services and the latter on making appointments and defining the scope of practice for individual medical practitioners.

Currently, although some practitioners may be registered, unless they are required to be registered through a Registration Board or are members of a professional association, community health services have no way of verifying their professional standing. In cases of misconduct or poor practice there is no avenue for community health services to report the relevant information to professional associations unless practitioners are members of the association as associations are unable to accept the information due to privacy requirements. Practitioners are able to apply for new positions and their clinical practice history cannot be checked with their discipline specific body.

As the national Registration process progresses it may be necessary to address the costs incurred by staff requiring registration with several bodies to undertake their work within community health eg Diabetes Educator, Nurse

Human Resource processes - organisations will be required to define roles, describe positions and essential criteria, shortlist applicants, undertake referee checks, police checks and appoint staff. Position descriptions will need to specify requirements for certification: registration, membership of professional organisations, professional development and/or accreditation. Agencies will need to credential practitioners before appointments are finalised. The Credentialing Committee will then review the information and any specific issues addressed. Appointments should be made subject to a three month review, which allows for confirmation by the Credentialing Committee. This may place some time pressures on the processes involved.

Clinical Leaders – access to advice from qualified clinical leaders in community health disciplines is required to effectively credential and define the scope of practice for individual practitioners.

In addition to their work with clients, a clinical leader's role in Credentialing and scope of practice could include:

- Advising on appropriate credentials required for scope of practice of relevant roles, especially to smaller agencies that do not have senior clinicians
- Supervising staff, especially those of the same discipline within specific community health services
- Assisting with the recruitment process to ensure staff have the required skills, experience and qualifications
- Providing orientation to new staff members on specific aspects of practice

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- Collaboration with professional bodies to update scope of practice frameworks for specific disciplines as required
- Providing feedback to agencies for use in general professional development programs, staff appraisal and performance management
- Developing links with other clinical leaders in similar roles.

It may also include:

- Coordination of discipline based meetings and coordination of clinical specific case conferences across defined areas
- Promoting area based coordinated intake and referral processes
- Providing a voice for clinical specific issues that may arise
- Advising services on clinical equipment requirements
- Supporting wholistic and multi-disciplinary approaches to service provision
- Coordinating professional development, training and education
- Providing advice on induction and professional development programs
- Informing agency managers of any circumstances, critical incidents, issues or events which may have an impact on service quality and outcomes
- Raising the overall standard and quality of staff performance, professional skills and responsibilities
- Building relationships with relevant area stakeholders including local referring agencies, HARP CDM Programs and associated Emergency Department, General Practice Divisions and Primary Care Partnerships.

Discipline specific clinical leader position descriptions will be required with benchmarks for supervision and clinical workloads. While agencies will be responsible for the level of remuneration, it is expected the position of clinical leader will be a new senior role reimbursed at a higher rate, a Grade 3. This would extend career opportunities in community health. Preferred minimum qualifications could include 7 years experience, a post-graduate qualification and significant experience in specialist areas. The work of Clinical Leaders and Line Managers would be integrated through regular meetings and reporting processes.

The development of these positions could build on the evaluation of the new clinical leadership positions in the HARP CDM Program in the EMR and there may be options to share the expertise of clinical leaders. If DHS employed statewide clinical leaders in the allied health professions this would facilitate the development of clinical leadership in the community health sector. Alternatively, regional or sub-regional clinical leaders funded by DHS could be appointed to lead agencies to support clinical supervision and the development of best practice.

There is widespread acknowledgement in the community health sector that state-wide good practice supervision guidelines are required for clinical staff in all areas to achieve quality management of service provision and best practice. Some community health services have managed to purchase limited external supervision. DHS throughput targets would need to be renegotiated to allow time for supervision and time for clinical leaders to support the Credentialing process, otherwise additional resources will be necessary. There are a number of options for the development of supervision and clinical leadership in community health, and ultimately the way forward will depend on the availability of resources.

Defining the Scope of Practice – While a statewide standard framework for defining the scope of practice needs to be developed for each discipline in community health, this must be applied separately for each individual at a particular site. Scope of practice would link to the Position Description and would inform what can be undertaken at a particular facility. Agencies will describe the scope of practice within each discipline in accordance with the standard frameworks developed and Credentialing committees will review the scope of practice determined by agencies. Ongoing collaboration with professional bodies and registration boards will be required to establish frameworks for each discipline and provide ongoing review and updating of these frameworks. The core competencies identified in some professions may not be sufficient to inform the process of defining scope of practice. Years of experience and practice expertise will inform you more about a practitioners capacity. Counselling and Occupational Therapy were suggested as professions to start with in a trial of the guidelines. The development of scope of practice guidelines for these professions is a substantial and valuable project that could occur either concurrently or separately to a pilot of the proposed model and guidelines recommended in this report.

Developing frameworks for defining the scope of practice will also involve DHS and VHA/CHV, clinical leaders and community health managers. Determining the scope of practice may be most difficult for positions in multi-disciplinary and wholistic teams that respond to a wide range of complex client needs. Definition of practice should encourage rather than restrict the development of multi-skilling.

Defining the scope of practice for individual positions at particular sites will assist community health services to define what they can and cannot do and which potential clients they will refer on.

Credentialing Committees - The role proposed for Credentialing committees is twofold: firstly, to contribute to the strategic and systemic development for Credentialing and defining the scope of practice in community health and secondly, to review, confirm and advise the Credentialing and scope of practice processes undertaken by agencies.

Credentialing an individual for a particular position in a particular service requires forming a view about competence and performance within a particular setting. It will be done by agencies on the basis of documentation submitted to them by the applicants. If requested by agencies, Credentialing

Committees can contribute their expertise to this process. Many stand alone community health services do not have the resources to establish an in-house Credentialing Committee and it may be challenging to undertake the administrative tasks required even when it is done on a regional or sub-regional level.

It is recommended that the composition of the Committees be multi-disciplinary and have input from consumer reference or advisory groups as these mechanisms develop. One of their roles will be to identify and foster clinical leadership and ensure it is accessible to community health service clinicians and program managers. Further details about the role and composition of these committees are provided in the Guidelines at **Appendix 3**.

There is likely to be a cost incurred in establishing and maintaining Credentialing committees. Members with specialist expertise may need to be paid for their time (or their agencies reimbursed), the committee will need to be serviced and confidential records generated and stored. Committees may also need to purchase specialist advice including legal opinions for particular issues.

DHS and the VHA/CHV Clinical Governance Steering Group, in association with the proposed pilot project, could oversee a process of consultation to confirm the role of Credentialing committees and develop consistent policy and procedures.

Credentialing may incorporate the current continuing development and accreditation programs of the various professions and eventually lead to mandatory association membership and accreditation. When a person is credentialed it will be transferable to another community health service within a three year time frame although individuals would still be required to inform their employer immediately if anything had occurred to change their standing and agencies would be responsible for ensuring the practitioner is suitably qualified for the position they were transferring to. Credentialing Committees are responsible for reviewing the Credentialing of staff appointed and confirming the appointment within three months of the commencement of employment and assisting agencies to effectively undertake the tasks of certification (verifying credentials), Credentialing (confirming practitioners can do what they claim on the basis of evidence) and confirming the scope of practice for a practitioner (defining what practitioners may do in a particular position at a particular site).

There is an option to focus on those aspects of Credentialing and defining the scope of practice that relate to improvements in current practice (organisational policies, supervision practices and common tools) before proceeding to establish Credentialing Committees

Temporary and emergency Credentialing process – this is necessary for short term and temporary appointments until the Credentialing Committee can confirm the relevant information. Verification of credentials and definition of the scope of practice of all employees is required prior to appointment.

Re-Credentialing process – as a minimum, every 3 years it is necessary to form a view about the competence and performance of staff and changes to the scope of practice within a particular setting.

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The re-Credentialing process will review the development of services to ensure clinical staff have the skills to undertake the work required of them and also take into account additional skills and qualifications obtained by staff. This will be done by the services in close collaboration with clinical leaders; the Credentialing Committee will provide advice and review the outcomes of this process.

Re-Credentialing requires professional clinical expertise to verify training, skills and organisational capacity. It is required on a regular basis as well as when new services are established. Shifts in service design and development may create a need for re-Credentialing.

The Guidelines and Tools provided as **Appendix 3** describe in more detail the common forms, policies and procedures required for Credentialing and defining the scope of practice in community health.

The Sequence of Events

The steps involved in Credentialing and defining the scope of practice involve the community health services, the Credentialing Committees, clinical leaders and the professional bodies. A guide to the sequence of events and who might be involved is outlined below.

	Activity	CHS	Credentialing Committee	Professional Bodies	Clinical Leaders
1	Establish C&SOP policy framework for CHSs	X	x		
2	Determine CHS roles and responsibilities	X			x
3	Determine Relevant SOP frameworks for disciplines	X	X	X	X
4	Determine CHS capabilities, levels of service provision	X	x		x
5	Determine SOP for individual positions	x			X
6	Evaluate new service proposals (as required)	X	x	x	x
6	Document Position Descriptions	X			x
7	Advertise Positions, seek C&SOP information	X			
8	Shortlist (SL) up to 3 applicant's	X			x
9	Select preferred applicant, check credentials, referees and references, appoint staff (subject to confirmation of C&SOP by committee)	X			x
10	Forward information on appointments made to the Committee for review	X			x
11	Review credentials including CPD/accreditation of preferred applicant or staff member and confirm proposed SOP		X	x	x
12	Document C&SOP findings and advice of Committee and BoM informed as part of the reporting process		X		

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13	Re-credential (routine)	Repeat from 10
14	Re-credential (new service)	Repeat from 5
15	If staff request re-Credentialing	Repeat from 10

Guidelines for the Credentialing and Scope of Practice Committees would be developed in a consultative manner with DHS and the VHA/CHV Clinical Governance Steering Group involvement to ensure statewide consistency.

While there will be slightly different models adopted in different catchments, a consistent and transparent process that can be held accountable is required to ensure the process of Credentialing and defining the scope of practice has credibility. The objective is to establish a consistent statewide approach with the flexibility to respond to local needs. Some acute and some primary care/community services have recently reviewed the credentials of existing staff members and as noted, an option is to commence Credentialing by “re-Credentialing” existing staff.

5. Recommendations

The recommendations support a coordinated incremental approach that integrates statewide planning, and a locally based pilot of the practical application of the model.

Recommendation 1

That the findings of the EMR project on Credentialing and Defining the Scope of Practice be **disseminated across the community health sector** (in collaboration with the VHA/CHV Clinical Governance Steering Committee) and that consultations be held to gather feedback and further a shared understanding of this initiative.

Recommendation 2

That consideration be given to establishing **Clinical Supervision/Leadership** within the Community Health sector and that this is progressed through a project with support from DHS and VHA/CHV.

Recommendation 3

That work be undertaken in collaboration with professional bodies and registration boards to develop a statewide **framework for defining the scope of practice** for disciplines within Community Health starting with Counselling and Occupational Therapy.

Recommendation 4

That the **tools** developed during this project are trialed as part of the work of the Clinical Governance Steering group.

Recommendation 5

That the **professional bodies** governing staff involved in providing clinical services to community health clients be informed of the findings of this project and given an opportunity to comment on the final report and contribute to the development of Credentialing and defining the scope of practice in community health.

Recommendation 6

That the **Human Resource function within the Community Health sector** is assessed as to its capacity to undertake this initiative and to identifying new approaches and personnel structures that may be able to contribute to the resourcing of this initiative.

Recommendation 7

That a **pilot** be conducted to test, scope, cost and further develop a model and structure of Credentialing and Defining the Scope of Practice in Community Health involving:

- Appointment of a lead agency that has the infrastructure to support a major pilot project
- Employment of a Fulltime Project Officer for at least one year (the EFT required may vary with the scope of the pilot project)
- A catchment covering the Outer East PCP and the Care in Your Community planning network
- Establishment of a Credentialing Committee
- Education and training of clinical staff and Boards of Management
- Trialling and refinement of the tools outlined in the Guidelines
- Identification and establishment of the Clinical Leadership and supervision required (the extent to which this is possible may depend on the resources available)
- Collaboration with acute health services and across community health services
- Integration with the policy and service development frameworks being developed in other areas of the health sector.
- Liaison with at least two professional bodies to define a scope of practice framework. Initially, Occupational Therapy and Counselling disciplines could be approached. (This would be done in conjunction with Recommendation 3)

Recommendation 8

That the **Primary Health, Quality and Safety and the Workforce Development Branch of the Department of Human Services** together with the existing VHA/CHV Clinical Governance Steering Group, contribute to the ongoing planning and development of Credentialing and defining the scope of practice in community health across the state and monitor the piloting of these recommendations. A nominated principal contact in DHS (Primary Health Branch) is required who carries responsibility for the further development of this work and the proposed pilot of the guidelines and tools developed by this project.

6. Implications

Integration with Other Initiatives

The support of DHS in the development of an implementation plan would ensure the scope of Credentialing and defining the scope of practice in community health is introduced in keeping with resource allocation and implementation timelines.

An ongoing Working Group of DHS representatives and the VHA/CHV Clinical Governance Steering Committee will be required to oversee progress of the development of clinical governance in community health in Victoria and to:

- Integrate Credentialing and defining the scope of practice in community health across acute and community sector
- Undertake a comprehensive process of consultation with stakeholders
- Develop record systems and promote electronic storage and retrieval of information
- Ensure reporting frameworks are consistent with existing quality monitoring mechanisms, such as ACHS, QICSA and other accreditation organisations, and
- Disseminate work that has been done and coordinate the work being done.

Current initiatives that relate to Credentialing and defining the scope of practice include:

- The implementation of “Care in Your Community”
- Quality initiatives, particularly the implementation of the Victorian Quality Council clinical governance framework
- “Better Skills, Better Care” and other workforce planning, recruitment, retention and development initiatives
- The HARP CDM Program
- The Early Intervention in Chronic Disease Program
- New Clinical Leaders in Dental, ABI, AOD and HARP CDM Programs
- Reforms to the Registration of Health Professionals
- Development of accreditation and continuing professional development programs of the health professions, and the
- Formation of Demand Management Review Discipline Specific Working Groups.

Implementation

The implementation of Credentialing and defining the scope of practice can be staged once there is an idea of where we are going, how long it might take to get there, who is going to do the work and how much it might cost.

Credentialing and defining the scope of practice is a complex issue that may cause some concern to existing staff. Consultation and the involvement of Boards and staff in decisions made regarding the development and implementation of the model may help to alleviate fears.

Once the trial is concluded and the model confirmed, the implementation could be staged along the lines outlined in the table below.

Possible Implementation Stages for Credentialing and Defining the Scope of Practice in Community Health					
Clinical Governance And Credentialing Policy Frameworks	Policy Frameworks + Verification Credentials Appointment	Policy Frameworks + Verification + Clinical Leadership /Supervision	Policy Frameworks + Verification + CI Leadership/ Supervision + Credentialing and Re-Credentialing	Policy Frameworks + Verification + CI Leadership/ Supervision + Credentialing, Re-Credentialing, Defining SOP	Policy Frameworks + Verification + CI Leadership/ Supervision + Credentialing, Re-Credentialing, Defining SOP + Integrated Quality Management

The tools required to implement Credentialing and defining the scope of practice are primarily forms and guidelines as outlined in **Appendix 3**, most of the forms could be completed on line and the necessary (minimum) information managed in a data base. There will also need to be ongoing and confidential electronic communication with the relevant professional bodies, performance monitoring and reporting, and confidentiality.

The tools developed as part of the EMR project should be subject to further scrutiny, consultation and piloted with a view to introducing them statewide.

Resources

The resourcing of this initiative is a critical factor primarily because the community health services and the primary care sector as a whole are relatively under resourced. In particular, the management and administrative structures have limited capacity to absorb new initiatives that require human resources.

Resources will be needed for:

- Managing the change process
- Establishing and maintaining Committee processes and support services
- Establishing and overseeing Clinical Leadership positions and providing clinical supervision
- Developing and maintaining the human resources infrastructure required in community health services.

Additional resources will be especially important in the establishment phase as initially all staff need to be credentialled. Implementation planning will assist in spreading the available resources and taking an incremental approach to providing statewide consistency to credentialing and scope of clinical practice in Community Health.

7. Appendices

Appendix 1 contains the **Literature Review** undertaken at the commencement of the project to inform our thinking and provide a platform for further development.

Appendix 2 provides **Information Lists on Professional Associations and Registration Boards** (developed by VHA/CHV and Southern Health) that will provide a useful resource for community health services when credentialing and defining the scope of practice of staff. There are three documents:

- Professional Associations Information Table (VHA/CHV)
- Discipline Registration Information Table (VHA/CHV)
- Health Professionals Credentialing Resource Table (Southern Health)

Appendix 3 contains the **Guidelines and Tools** developed during the project including:

- A checklist for services implementing Credentialing, defining the scope of clinical practice
- A table of the sequence of events for the Credentialing, defining the scope of clinical practice and appointment process.
- Draft application forms for Credentialing and re-Credentialing in community health
- Draft Terms of Reference for a Credentialing and Scope of Practice Committee.

Appendix 1 Literature Review

Appendix 2 Information Lists on Professional Associations and Registration

Appendix 3 Guidelines and Tools for Credentialing and Defining the Scope of Practice

Appendix 4 Application Form

Appendix 4: Application Form

Credentialing and Defining the Scope of Clinical Practice

Community Health Service Application Form

Purpose

This form is designed to gather relevant information from the applicant to verify the qualifications, experience and professional standing of the applicant for the nominated employment position. Additionally, this information allows the organisation to determine the suitability of the applicant for the particular role they are to undertake. The applicant is required to complete this form as part of the recruitment process for this service.

Individual Details

Name (Given name, then surname)

**Residential
Address**

Phone No _____ **Mobile** _____ **Fax** _____

Email _____

Qualifications Please list all relevant tertiary qualifications, the date awarded and attach copies

Institution

Date _____

Institution

Date _____

Institution

Date _____

Institution

Date _____

Application for Scope of Practice

Please attach the details of the scope of practice you are requesting from the health service on the FORM SPECIFIC TO YOUR DISCIPLINE

Professional Registration

Please state which Professional Body (or bodies) you are eligible for registration with. If registered provide details and attach copy of current registration.

Professional Accreditation (if formally provided by the organisation that represents your profession)

Please state which Professional Body you are accredited with. Attach a copy of current accreditation documents.

Professional Development Activities

Please list professional development activities undertaken in the last year.

Professional Experience

Years of formal/informal supervised practice *please give egs and details*

What is your current position/s

1 _____

2 _____

How long have you been employed in your current position/s

1 _____ 2 _____

Who was your last employer and what was your position?

How long were you in your previous position?

Please provide some information about the areas you have experience in, including any specialties:

Please provide some information about the areas you have an interest in:

Please outline any knowledge or fluency you have in other languages:

Please outline any knowledge you have of specific cultural communities or special needs groups such as people who are homeless, have poor mental health, alcohol and drug problems or a disability.

Is there anything you wish to add?:

Private Practice Profile (only to be completed if relevant)

Practice Address, if in private practice

Phone No _____ Fax _____ ABN _____

Email

**Services
Provided**

**Years in
operation**

Supervision arrangements (include qualifications of Supervisor):

Details of Insurance Cover (Attach copies of current policies):

Disclosure

Has your scope of practice and/or appointment at any clinic or community health service ever been reduced, suspended or revoked, or have you had conditions attached to that appointment for any reason?

No _____ Yes _____ If yes, please provide details:

Have there ever been any adverse legal or disciplinary findings made against you which would be relevant to your position?

No _____ Yes _____ If yes, please provide details:

Referees

Please supply the names and contact details of at least three referees who can comment on your experience.

Referee

1. _____

Referee

2. _____

Referee

3. _____

Declaration

(please circle)

I authorise the health service to conduct a police record check in relation to my history.

Yes No

I authorise access to the above information by representatives of the health service's Credentiailling Committee

Yes No

I authorise the health service to seek information as to my past experience, performance and current fitness to practice

Yes No

I agree to notify the Chief Executive Officer of any event/situation which may impact on my ability to exercise my scope of clinical practice

Yes No

If appointed I agree to familiarise myself with the organisation's policies and procedures and abide by them

Yes No

I,.....(insert name)

Declare the information contained in this application is true and correct.

Signature _____ Date _____

Return to: Community Health Service

Please attach the relevant documents and any additional information

Re-Application Form

Credentialing and Defining the Scope of Clinical Practice

Community Health Service RE-APPLICATION Form

Purpose

This form is designed to gather relevant information from the applicant to verify and review the qualifications, experience and professional standing of the applicant for the nominated employment position. Additionally, this information will be used to determine any changes to scope of practice that may have occurred since initial Credentialing and Scope of Clinical Practice processes were undertaken.

Please attach relevant recent documents relating to your professional qualifications and experience to this application.

1. Individual Details

Name (Given name, then surname)
documents)

Previous Surname (if on

Residential
Address

Phone No _____ Mobile _____ Fax _____

Email _____

2. Re-Application for Scope of Practice

I wish to re-apply for the scope of practice which I was previously granted with no changes.

Yes No

If yes please go to Question 3

Please attach the details of the scope of practice you are requesting from the health service on the FORM SPECIFIC TO YOUR DISCIPLINE

OR

I wish to limit the scope of practice which I was previously granted

Yes No

If yes please outline the change to your scope of practice

OR

I wish to apply for an extension to the scope of practice which I was previously granted

Yes No

If yes please outline the change to your scope of practice

Outline training relevant to the extended scope of practice. Where relevant, include the title of the course/s undertaken, the organization offering the course and any qualifications obtained.

Referees

Please supply the names and contact details of at least two referees who can comment on your experience.

Referee

1. _____

Referee

2. _____

Referee

3. _____

3. Professional Development Activities

Please list professional development activities undertaken in the last year.

Have you satisfied the continuing professional development or accreditation requirements for your professional association membership?

Yes No

Comment:

4. Disclosure

Since your last Credentialing have there been or are there pending any claims, settlements or judgments against you?

Yes No

If the answer is yes please provide an explanation of each matter

Since your last Credentialing have you been the subject of any disciplinary actions/criminal activity?

Yes No

If the answer is yes please provide an explanation of each matter

Since your last Credentialing have you been convicted of a drug or alcohol related offence?

Yes No

If the answer is yes please provide an explanation of each matter

If you require further space to answer questions, please attach separate pages.

5. Health Status

Since your last Credentialing have you developed a disability/health impairment that might compromise your ability to perform any of the cognitive and physical functions related to the clinical work you may be required to perform?

Yes No

If the answer is yes please provide an explanation of each matter

Declaration

(please tick)

I authorise the health service to conduct a police record check in relation to my history.

Yes No

I authorise access to the above information by representatives of the health service's Credentialing committees.

Yes No

I authorise the health service to seek information as to my past experience, performance and current fitness.

Yes No

I agree to notify the Chief Executive Officer of any event/situation which may impact on my ability to exercise my scope of clinical practice

Yes No

If appointed I agree to familiarise myself with the organisation's policies and procedures and abide by them.

Yes No

I,.....(insert name)

Declare the information contained in this application is true and correct.

Signature _____

Date _____

Please note: If for any reason you are unable to sign the Declaration above, please attach an explanation of the circumstances.

Return to: Community Health Service

Please attach the relevant documents and any additional information