Credentialing and defining the scope of practice of Rural Generalists

Credentialing and defining the scope of practice are essential processes in maintaining standards of clinical practice to ensure that patients can have confidence that they are receiving high quality and safe medical care wherever they choose to live or travel in Australia.

Providing high quality and safe medical services in rural and remote areas requires that appropriately skilled doctors[1] be matched to communities that need those skills. While significant work has been done to identify health care needs in various areas (including the Atlas of Healthcare Variation[2], and Primary Health Networks' needs assessments), matching medical skills and knowledge to the community can still be problematic. This issue is exacerbated by credentialing and defining scope of practice processes that are onerous, duplicative and do not necessarily reflect the complexity, circumstances and scope of rural generalist medical practice. This, together with the closure or downgrading of rural health services and declining infrastructure, are disincentives for doctors to move to or provide locum services in rural and remote communities.

While guidelines exist to assist health organisations, there a number of inconsistencies and inefficiencies in the ways in which credentialing and defining scope of practice processes for medical practitioners are implemented across Australia:

- Application processes are often burdensome requiring doctors to provide information and documentation to each hospital or local area health service[3]. This can be challenging in rural and remote areas particularly if doctors work across more than one hospital district and/or across state or territory borders. Rural and remote locums, for example, often work in several locations in a year sometimes for just a few days.
- Inconsistency in use of language and terms by States, Territories or area health services can be problematic.
- Delays in appointing permanent or locum medical practitioners can leave rural and remote communities with no local medical care which can be costly not only for patients but also for the health system if they need to seek treatment in more distant Emergency Departments.
- Scope of practice limitations determined by a rural facility's Clinical Services Capability Framework (CSCF) may not necessarily align with the scope of practice that an individual medical practitioner's qualifications and skills may warrant. For example, a Rural Generalist with an advanced procedural skill may be credentialled to provide

[1] While this document focuses on the credentialing and scope of practice of rural generalists, RDAA recognises that these processes for resident and visiting specialists in rural and remote areas are also problematic.
[2] Australian Atlas of Healthcare Variation Series**.** Available at https://www.safetyandquality.gov.au/atlas/. Viewed 09 July 2019
[3] Different jurisdictions have different names for local area health services, including Local Health District (LHD), Local Hospital Service (LHS), Hospital and Health Service (HHS) and Area Health Service (AHS).

services in their local health area service but not in the adjoining area. This situation can create unrealistic expectations of the service on the part of patients who may not fully understand the hospital's limitations. Where no provision is made for emergency procedures that may fall outside the CSCF of a rural facility, a Rural Generalist may be subjected to unfair scrutiny of their clinical practice if called upon to perform these procedures – for example, a Burr Hole surgery for extra dural haematomas – without consideration given to the specific context in which the procedure was performed.

- Disconnected and slow credentialing processes, together with diminishing rural and remote health services, also constrict the capacity of doctors to work to the top of their scope of practice and act as a disincentive to practice in rural and remote areas, increasing the burden on rural and remote Australians who already experience poorer access to health professionals and services and consequent poorer health outcomes.
- Other organisations, such as Regional Training Organisations (RTOs), setting limitations on scope of practice can also be problematic and costly when a doctor's scope of practice is determined by organisational requirements rather than by credentialing committees. RTOs have been known to place supervisory restrictions on doctors credentialled in an advanced skill but not fully fellowed, limiting options, exposure and service delivery.

Position

Efficient and effective credentialing and defining scope of practice administrative processes are necessary to ensure that patients in rural and remote areas are not disadvantaged by inflexible arrangements that compromise their access to doctors with the skills needed in their community. RDAA recommends streamlining current arrangements by:

- clearly articulating key principles[4] to underpin all credentialing and defining the scope of practice processes across Australia
- developing national guidelines for determining the scope of practice and the credentialing of rural generalists, that include nationally agreed terms and language usage, to ensure that these processes do not act as barriers to accessing medical care in rural and remote areas. Then, at the local level, the CSCF and the individual's clinical skills should determine any limitations. Exceptions to these limitations in emergency situations should be clearly articulated. The development of these national guidelines should be tasked to the Rural Health Commissioner and Chief Medical Officer in consultation with an expert reference group that includes practising Rural Generalists, representatives from the two general practice colleges, and regional procedural and non-procedural specialist representatives from other specialty colleges to inform the planning and establishment of the National Rural Generalist Pathway
- setting national standards for rural generalist practice that are agreed by the Australian College of Rural and Remote Medicine and the Royal Australian College of General Practitioners, with input from other specialist colleges such as the Australasian College for Emergency Medicine where appropriate
- ensuring currency of these guidelines and standards through continual review and incorporation of new evidence and changes to best practice

[4] Suggested governing principles are at Appendix A.

- developing a nationally consistent approach to the collection of applicant information and documentation, including by:
    - developing a common format for the general information and documentation needed by all credentialing bodies and the Medical Board of Australia/Australian Health Practitioner Regulation Agency (AHPRA)
    - holding information and documentation in a secure national repository administered by an organisation such as the Medical Board of Australia with defined permitted access arrangements for the Specialty Colleges and credentialing bodies
    - developing user friendly applications and a cloud-based web portal accredited by the Information Security Registered Assessors Program (IRAP) for ease of use by clinicians
    - ensuring systemic checks and balances are utilised efficiently. They must meet industry needs and be necessary (not carried out to tick a box).
- ensuring credentialing committees include peer review. Sufficient numbers of practising rural generalists with the relevant advanced skill/s as well as their specialist colleagues who have an understanding of rural generalist practice in the Australian context[5] must comprise these committees.
- including direct input from rural and remote medical practitioners and health services in CSCF development and review processes to ensure levels are aligned with scopes of practice that reflect community need and capabilities of the local service.

Conclusion

To ensure safety of patients and quality of health care in rural areas credentialing and defining scope of practice arrangements in these areas must take into account the context in which they exist. National principles, guidelines and standards for Rural Generalist practice supported by mechanisms to streamline requirements and processes are a much-needed step to improve access to the highly trained medical workforce needed in rural and remote areas.

[5] Where specialists with this understanding are unavailable, rural and remote education and orientation programs may be needed.

Background

- Definitions, guidelines and standards

Defining Credentialing and Scope of Practice

To protect patients and their treating practitioners, health organisations and services "are required to appoint health practitioners who are suitably experienced, trained and qualified to practise in a competent and ethical manner in accordance with service needs and organisational capability." [6]

Credentialing is the "formal process used to verify the qualifications, experience, and professional standing of doctors for the purpose of evaluating their competence, performance and professional suitability to provide high quality health care for patients within specific organisational environments."[7]

This process to determine a clinician's ability to provide safe, high quality health care services within specific health care settings and ensure that they practise within the bounds of their training and competency is part of a broader quality assurance and risk-management system put in place to protect patients and promote safe health care.

Within this context, scope of practice[8] may be defined as "the professional role and services that an individual health practitioner is trained, qualified and competent to perform. A medical practitioner's scope of practice may include clinical and non-clinical practice."[9] Defining the scope of practice involves delineating the extent of an individual health practitioner's practice within a particular organisation.

The Medical Board of Australia requires medical practitioners to recognise and work within the limits of their competence and scope of practice [10]. Health services and organisations set the parameters for scope of practice for each of their positions and require that medical practitioners demonstrate attainment of minimum credentials for the position.

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[6] The Australian Commission on Safety and Quality in Health Care. 2015. p4. *Credentialing health practitioners and defining their scope of clinical practice – A guide for managers and practitioners*. https://www.safetyandquality.gov.au/wp-content/uploads/2016/02/Credentialing-health-practitioners-and-defining-their-scope-of-clinical-practice-A-guide-for-managers-and-practitioners-December-2015.pdf. Viewed 09 July 2019.

[7] Australian Council for Safety and Quality in Health Care. 2004. *Standard for Credentialing and Defining the Scope of Clinical Practice: A national standard for credentialing and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals. p3.* https://www.safetyandquality.gov.au/sites/default/files/migrated/credentl1.pdf Downloaded and viewed 11 July 2019.

[8] "Clinical privileging" has also been widely used as an alternative term to describe the scope of clinical practice.

[9] Medical Board of Australia. *FAQ: Recency of Practice.* http://www.medicalboard.gov.au/Codes-Guidelines-Policies/FAQ/FAQ-Recency-of-practice.aspx. Viewed 09 July 2019.

[10] Medical Board of Australia. *Good medical practice: A code of conduct for doctors in Australia.* http://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-conduct.aspx. Viewed 09 July 2019.

Current credentialing and defining the scope of practice guidelines and standards

Although the 2004 *Standard for Credentialing and Defining the Scope of Clinical Practice: a national standard for credentialing and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals* (the Standard)[11] was implemented in all jurisdictions in the public and private sectors, the structures and processes used varied across states and territories with some using a statewide system and others using a local health area system.

The first edition of the *National Safety and Quality Health Service (NSQHS) Standards* (the Standards) was initially released in 2011, and used to assess health service organisations from January 2013. A number of supporting documents covering the implementation and use of safety and quality systems in a range of areas were also made available[12]. A *Review by Peers – A guide for professional, clinical and administrative processes* (2010) also developed by the Commission provided 'how to' advice to maximise the effectiveness of peer review processes and increase reliability of the outcomes[13]. The second edition of the Standards, released in November 2017, comprises eight standards that together with Clinical Governance and Partnering with Consumers Standards form the clinical governance framework for health service organisations[14].

State and territory specific material is also used to guide the implementation of credentialing processes. In 2015, *Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners* was published as an ancillary guide "to provide practical guidance for managers and practitioners responsible for credentialing, and for determining and managing, a health practitioner's scope of clinical practice …It **does not** replace or supersede state, territory or organisational policies on credentialing."[15] Scopes of practice at a local level are determined by the clinical capability of the particular facility regulated by jurisdictional CSCFs.

It is important that the review process for guidelines and standards are cognizant of the three-year accreditation cycle under which health facilities operate – there are implications for both the implementation of new standards and guidelines and for any remedial actions

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[11] Australian Council for Safety and Quality in Health Care. 2004. *Standard for Credentialing and Defining the Scope of Clinical Practice: A national standard for credentialing and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals.* https://www.safetyandquality.gov.au/sites/default/files/migrated/credentl1.pdf Downloaded and viewed 11 July 2019.

[12] https://www.safetyandquality.gov.au/standards/nsqhs-standards/implementation-nsqhs-standards#the-nsqhs-standards. Viewed 09 July 2019

[13] https://www.safetyandquality.gov.au/our-work/assessment-to-the-nsqhs-standards/resources-to-implement-the-nsqhs-standards/#Safety-and-quality-improvement-guides. Downloaded 20 March 2018. Viewed 18 June 2018.

[14] https://www.safetyandquality.gov.au/standards/nsqhs-standards/implementation-nsqhs-standards#the-nsqhs-standards. Viewed 09 July 2019.

[15] The Australian Commission on Safety and Quality in Health Care. 2015. *Credentialing health practitioners and defining their scope of clinical practice – A guide for managers and practitioners*. https://www.safetyandquality.gov.au/wp-content/uploads/2016/02/Credentialing-health-practitioners-and-defining-their-scope-of-clinical-practice-A-guide-for-managers-and-practitioners-December-2015.pdf. p4. Downloaded and viewed 09 July 2019.

arising from accreditation processes – and be continually updated to incorporate learnings, new evidence and changes to best practice to ensure currency.

• Key Issues

Approaches to credentialing are inconsistent

RDAA supports having a mechanism for reviewing a doctor's standard of clinical practice to ensure the highest possible quality of medical care and safety for patients.
However, interpretation and application of standards and guidelines, and approaches to credentialing vary across State/Territory and local area health services levels and do not necessarily reflect the circumstances and complexity of rural and remote practice.

All jurisdictions also have, or are introducing, clinical services capability/role delineation frameworks that establish criteria for service planning and delivery in public hospitals and licenced private health facilities. They have been in place for a number of years in some States. Victoria, following the release of the Report of the Review of hospital safety and quality assurance in Victoria[16] has developed a clinical governance framework[17] for its health services.

While there is some consistency as a result of development and review processes drawing on the models of from other jurisdictions, there is also a degree of local variation that contributes to duplicative and burdensome bureaucratic processes.

Given that these frameworks underpin service planning and delivery they have or will have a significant impact on credentialing processes. It is critical that they be used to improve quality and service, not as a rationalisation for reducing services in rural communities.

Standards and credentialing and defining the scope of practices processes do not necessarily reflect the complexities of rural and remote practice

The setting of standards for credentialing and defining the scope of clinical practice presents a number of difficulties. Committees responsible for the setting of standards, credentialing and defining the scope of practice of rural doctors do not always have appropriate peer representation and therefore may not fully appreciate the complexities of rural practice. Examples include:

- Requiring that a minimum number of procedures be undertaken annually to be credentialed in a procedural skill can create problems in rural areas where this cannot be guaranteed. There is no evidence to suggest that volume of procedures is

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16 *Targeting zero Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care: Report of the Review of Hospital Safety and Quality Assurance in Victoria* https://www.dhhs.vic.gov.au/sites/default/files/documents/201610/Hospital%20Safety%20and%20Quality%20Assurance%20in%20Victoria.pdf. Downloaded and viewed 11 July 2019.

17 *Safer Care Victoria (2017). Delivering high-quality healthcare - Victorian clinical governance framework*. Available at https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Delivering-high-quality-healthcare-Victorian-clinical-governance-policy. Viewed 09 July 2019.

important in maintaining safe practice. Other arrangements to ensure that the Rural Generalist is able to maintain their skills should be adopted.

- Standards that are based on quite basic training can be problematic where there is an assumption that a medical practitioner having completed, for example, basic Rural Emergency Skills Program (RESP) training is competent to work in any rural hospital. Concerns with underperformance by doctors (and consequent management issues) may arise.
- Regular course-based skills maintenance provides a limited affirmation of skills maintenance and competency. Individual peer review of procedural practice and 360 degree feedback should be used to provide evidence of procedural skill.

The risk of bureaucratic control compromising patient care and undue influence by specialist groups in defining the scope of practice of rural generalists must also be acknowledged.

To avoid these issues:

- the scope of practice for Rural Generalists in relation to area of advance skills as well as general practice must be defined by rural and remote GP practitioners, rural generalists with the same advanced skill, and their specialist colleagues to ensure collective understanding and confidence in quality and safety practises
- standards for Rural Generalist practice must be set and agreed by ACRRM and the RACGP, with input from other specialist Colleges where appropriate
- there should be no requirement that an annual minimum number of procedures be undertaken in order to be credentialed in a procedural skill
- credentialing and defining the scope of practice processes must involve peer review. Credentialing governance committees must include a peer with the specific skill set of the doctor being credentialled. For example, a doctor seeking to be credentialled as a GP obstetrician must be assessed by a committee that includes a practising GP obstetrician. There are examples of the credentialing process where rural and remote doctors are reviewed by peers as well as by specialist colleagues, ensuring a robust mechanism to maintain a high standard of patient safety and quality services in rural and remote areas. These examples could provide the basis for the development of national guidelines for the credentialing of rural and remote doctors.
- development and review of CSCFs must be informed by rural and remote perspectives to ensure levels are aligned with scopes of practice that reflect community need. Where community need exceeds the current CSCF, this will require additional investment in workforce and often in infrastructure.

Rural doctor representation on relevant MBS Review Clinical Committees is also important to ensure that the rebate for particular procedures is the same whether it is performed by a specialist or by a credentialed advanced skill rural practitioner.

Other organisations, such as RTOs, setting limitations on scope of practice is also a concern. For example, doctors who have completed requirements in a specific advanced skill and have been certified as capable in that skill by the relevant College (but have not completed their full Fellowship) are allowed to practise independently in their advanced skill in some places but not in others. This variability is in part due to supervision requirements by some RTOs rather than determined by credentialing committees.

Credentialing these doctors to work independently in their certified advance skill area can improve access to those services in rural and remote areas by maximising limited resources through improved rostering flexibility and reduced costs for supervision. It is important, however, to recognise that while college training articulates level of capability there may be less access to professional support if needed, and therefore the supervision or support arrangements need to be tailored to the individuals' needs and capacity of the service. While registrars practising in more urban settings can get almost immediate onsite help, registrars practising in rural and remote areas may have to access remote support/supervision or call-in arrangements that may have up to a 30-minute delay for onsite attendance. It essential to ensure robust procedures to utilise Rural Generalist networks and tele-specialist support are in place.

Inconsistent use of terms can be problematic

Terms – such as supervision, clinical lead, and clinical management – must be clearly defined and nationally agreed and consistently used to prevent misinterpretation and possible legal ramifications. The term 'supervision', for example, has legal implications but can be used differently by jurisdictions and local area health services.

Duplicative bureaucratic processes are burdensome

Administrative processes for credentialing and defining the scope of clinical practice can be repetitive, time consuming and onerous. There are a number of examples where alignment of required information across processes could reduce this administrative burden on time poor doctors. For example, information required for recruitment purposes is not necessarily transferred for credentialing. Information provided to specialty colleges for Continuing Professional Development (CPD) to maintain Fellowship also often duplicates the credentialing requirements.

While some states use, or are moving to adopt, e-Credentialing systems to create digital credential profiles available to any hospital/health facility (with the individual doctor's permission) to streamline credentialing administrative processes, alignment issues remain. These include the use of online processes in one area and paper-based processes in another within the same jurisdiction, and a seeming lack of trust within the system – local area health services appear unwilling to trust another's assessment of a doctor's competence, even for hospitals with similar profiles – possibly due to the onus of accountability.

A national repository for information – administered by an organisation such as the Medical Board with permitted access for Specialty Colleges and employers – which allows individual doctors to upload their qualifications and CPD information, could address the alignment and lack of trust issues. Nationally standardised applications and a cloud-based web portal that are IRAP accredited should be developed as a priority to support clinicians' access to their records.

There is a continuing decline in local rural health infrastructure and services that is negatively impacting on workforce capacity

Defining the scope of clinical practice (clinical privileging) is as much about the clinical capacity and the capital infrastructure of hospitals/facilities as it is about assessing

doctors' competencies. Rural hospitals are seeing a contraction in clinical capability as a result of local interpretations of clinical privileging guidelines being applied.

It is well recognised that over time there has been a steady decline in locally provided health services in rural and remote areas, whether it be through the full or partial withdrawal of services, the closure of specific units, repurposing of rural hospitals or the removal or non-replacement of equipment. The 2017 closure of the maternity unit and the removal of paediatric and some surgical services in the Mersey Community Hospital in north-west Tasmania is an example.

This decline is continuing, negatively impacting on the scope of clinical practice of rural generalists, and creating gaps in the provision of high-quality local health care for rural and remote patients, further compromising their health outcomes – already poorer than those of people living in urban centres. This will also negatively impact on training options for future rural generalists.

In some instances, the clinical capacity of hospitals/health facilities, and the limitations placed on the scope of practice of medical practitioners as a result of bureaucratic decisions which fail to take into account the needs of rural and remote patients or the circumstances of rural practice, being reinforced through credentialing and defining scope of practice processes, are the key limiting factors in providing high quality health services to rural and remote areas. Any clinical governance decision made on safety grounds should be supported by appropriate data and evidence.

Credentialing processes for anaesthetics, for example, are markedly different from state to state, and restrictions on who can administer paediatric anaesthesia exist and are determined by the age of the child as well as other factors such as qualifications and currency of practice. GP Anaesthetists in Australia generally have an excellent safety record but may be governed by inflexible regulations that can have unintended effects. An instance where, because of patient age restrictions, a GP Anaesthetist was only able to give sedation rather than being allowed to anaesthetise a child with a large laceration requiring suturing led to an Emergency Department (ED) doctor performing the procedure in the ED even though a general surgeon was available. This illustrates the issue of inflexible arrangements that can place patients in avoidable higher risk situations. Clear regulations governing the provision of services in special situations that fall outside normal guidelines need to be developed. These regulations must take into account patient safety, local resources and the emergent nature of treatment required.

The broader implications of this decline for the long-term provision of health services by appropriately trained and skilled health care professionals cannot be ignored. Ensuring that clinicians are able to practise their advanced skill is essential for the recruitment and retention of the highly skilled workforce necessary to provide for the needs of rural and remote communities.

Rural generalists want to work in places where they can practise their advanced skill. If rural generalists having procedural or non-procedural advanced training and skills cannot be credentialled to practise those skills because of organisational clinical capacity restrictions they will choose to locate to places that offer them this opportunity over those that do not. If changes to health service provision mean that they can no longer practise within the local area they may, if the option is available, travel to facilities further afield in order to

practise their advanced skill – reducing the time they are available to their immediate community – or they may simply seek to move all together.

The domino effect on other health professionals and impact on local hospitals must also be considered. For example, if rural doctors do not offer procedural services theatre nurses will not be required. Allied health services may also be impacted.

Opportunities exist to reverse this decline. For example, enabling rural hospitals to operate using a rural generalist model of care may see a return to service delivery. The National Rural Generalist Pathway as part of a broader approach to training, recruitment and retention of medical practitioners in rural and remote areas offers a way forward but it is not a panacea. It is critical that, until the National Rural Generalist Pathway is established and fully operational, local rural health infrastructure and services are maintained.

Closing or downgrading grading local rural health services will impact negatively on rural and remote people and communities

Local health services are integral to the socio-economic fabric as well as the health of rural communities, including by providing prevention and community education and employment within the community. The potential negative impacts of closing or downgrading these services include diminished physical and mental wellbeing of individuals, poorer patient health outcomes, and broader socio-economic decline in rural and remote communities as well as increased pressure on the overall health budget.

APPENDIX A

Suggested governing principles for the development of national guidelines

The first principle underpinning credentialing and defining scope of practice processes must be that the safety of patients and quality of health care is paramount.

Guidelines and standards governing credentialing and scope of practice must be nationally consistent and reviewed regularly to ensure adherence to best practice.

Credentialing and defining scope of clinical practice processes must be streamlined, transparent and underpinned by robust governance and accountability mechanisms.

Standards outlining the accepted scope of clinical practice for Rural Generalists must be agreed and endorsed by both ACRRM and the RACGP (and by ACEM or other specialist colleges where appropriate). These should incorporate sets of standards for advanced skills to underpin credentialing processes.

All rural credentialing committees must include practising rural generalist representatives from the same craft group.