

# EMPOWERING ALLIED HEALTH SERVICE DELIVERY USING INTEGRATED CREDENTIALING AND SCOPE OF PRACTICE SYSTEMS

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## EXECUTIVE SUMMARY

Integrated credentialing and scope of practice (CSOP) systems not only safeguard patients; they are a catalyst for innovation and empower health service delivery. An integrated CSOP system ensures regulatory compliance, delivers safe and skilled care, empowers clinicians to expand their capabilities, and enables professions to adapt and innovate within the health system. This report outlines the implementation of a sophisticated CSOP system across 25 Ahpra-registered and self-regulating Allied Health professions within a large metropolitan public health network.[1] With over a decade of refinement, the system enhances service delivery by enabling structured expansion of professional and individual scope of practice, supported by profession-specific CSOP documents, risk-informed processes, and an electronic credentialing platform.[2] In a three-year period, the system has credentialed 1,017 newly employed clinicians, has endorsed 846 changes to individual scope of practice, and has implemented 42 profession-wide scope of practice changes, demonstrating significant impact on workforce capability and patient care.

## PROBLEM

The health service provides services across the lifespan at more than 40 sites, with the allied health team consisting of 1,900 professionals and assistants from a diverse mix of 25 Ahpra-registered and self-regulating professions. In addition, it operates in a context where governance responsibilities are devolved to the organisation. This results in significant complexity related to the implementation of CSOP processes.

CSOP processes ensure clinicians are professionally suitable, competent, authorised, and supported to deliver care they are accountable for, within a specific organisational context.<sup>3</sup> Historically, processes were limited to verifying required registration/ certifications, qualifications and experience at recruitment, with inconsistent storage of documentary evidence. Processes did not define individual scope of practice beyond a position description, have mechanisms to expand profession or individual scope of practice, nor enable accurate regulatory compliance tracking such as Ahpra registration.[1] Early processes were manual, inconsistent and lacked transparency and agility, making it difficult to identify clinical practices where additional safeguards were warranted.[2]

## INTERVENTION

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The health network implemented an integrated, risk-informed CSOP system with four key components.

### **PROFESSION-SPECIFIC CSOP DOCUMENTS:**

Developed for 25 professional groups, these documents outline credentialing standards and the available scope of practice for a profession in the organisation.[3,4] They enable delineation of individual scope of practice and are used during recruitment, clinical supervision and scope of practice reviews. Skills beyond routine scope of practice for a profession are listed and categorised using a decision tool according to their risk profile, as either core, additional or specific skills[5]. Additional or specific skills have safeguards that reflect their risk profile. The safeguards vary from reflective practice to formal micro-credentialing against a credentialing standard.

### **MECHANISMS TO EXPLORE AND EXPAND PROFESSION SCOPE OF PRACTICE:**

Consistent processes are applied to evaluate proposed changes to professional scope of practice, focusing on risks and mitigation strategies using our '3 Ps' model. This model explores; the extent of the clinical **Practice**, the **Practice** context i.e. where it will be implemented and what are the available supports, as well as how **Practitioner** competence will be determined. If formal micro-credentialing is required for a skill, a standard is set and endorsed by professional governance decision makers, authorisation processes are determined, and the new scope of practice is integrated into CSOP documents, platforms and processes. Where competency-based training in our workplace is relied on for credentialing, these programs are implemented using a structured evidence-based method.[6]

### **CONSISTENT PROCESSES TO CHANGE INDIVIDUAL SCOPE OF PRACTICE:**

Once a skill is available for the profession and is categorised and listed on the profession's CSOP document, individuals can apply to change their individual scope of practice through the electronic credentialing system. The risk profile of the skill determines the extent of the review process and the evidence required to support credentialing decisions. When endorsed, the individual scope of practice will be visible on an organisational-wide credentialing register.

### **ELECTRONIC CREDENTIALING SYSTEM:**

Centralises credentialing records and documentary evidence, monitors Ahpra registration in real-time and manages applications for individual scope of practice changes. In addition, it allows for declarations against standards for self-regulating professionals and enables the regular review of individual scope of practice.[5]

## LEARNING

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There are four main insights from the 10-year development journey.

### **FOCUS ON RISKS AND CONCERNS:**

It is neither practical nor desirable to credential every skill. Instead, credentialing should be targeted to higher-risk skills, with due consideration for stakeholder concerns.

### **COLLABORATIVE DESIGN:**

Engagement with clinicians and decision-makers ensures relevance and usability of documents and processes. It fosters trust, addresses individual concerns respectfully, and promotes shared ownership of solutions.

### **DEDICATED RESOURCING:**

The system relies heavily on developed expertise and to sustain the system, ongoing investment is essential.

### **CONTINUOUS IMPROVEMENT:**

Ensures that documents and processes reflect contemporary practice and standards, as well as mitigating emerging risks.

## IMPACT FOR PRACTICE

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Over a three-year period, the integrated CSOP system has delivered measurable benefits, credentialing and defining the scope of practice for 1,017 new allied health clinicians at recruitment, enabling 846 clinicians to expand their scope of practice, and implementing 42 profession-wide changes to scope of practice within our context.

Expansions to profession scope of practice, have empowered allied health service delivery, here are some examples: Waitlists for access to consultant care in our ear, nose and throat clinics have been reduced by enabling Speech Pathologists to work to the top of their scope and perform nasendoscopy with administration of nasal anaesthetic sprays; service delivery changes in home-based allied health have been supported by the implementation of trans-professional skill sharing; with credentialing for criterion led mobility progression we have been able to optimize the use of Allied Health Assistants and release time for Physiotherapists in the inpatient setting; Advanced Musculoskeletal Physiotherapists providing primary contact care in the emergency department, can be credentialed to initiate and administer single dose analgesics, ensuring patients have timely access to pain relief.

Ultimately, credentialing and scope of practice systems are not merely compliance tools; they are enablers of safe, effective, and innovative care. Organizations adopting similar frameworks can expect improved governance, workforce capability, and patient access.

### References

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