Leukaemia Foundation

# Scope of Practice Review survey response – March 2024

More details: Scope of Practice Review

## Legislation and regulation

1. What do you believe are the key legislative and regulatory reforms which have the potential to most significantly impact health professionals' ability to work to full scope of practice? (For example, harmonisation of specific legislation between jurisdictions, or regulating health professionals differently.)

**n/a**

2. A risk-based approach to regulation names core competencies, skills or knowledge capabilities required to authorise a health professional to perform a particular activity, rather than relying solely on named professions or protected titles. To what extent do you think a risk-based approach is useful to regulate scope of practice?

**n/a**

3. Please provide any additional comments you have on the risk-based approach to regulation.

**n/a**

4. What do you see as the key barriers to health professionals' authority to make referrals across professions?

**n/a**

## Employer practices and settings

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**1. What changes at the employer level would you like to see to enable health professionals to work to full scope of practice? (For example, changes to credentialling, practice standards, clinical governance mechanisms or industrial agreements)**

**n/a**

**2. Which particular activities or tasks within health professionals' scope of practice would you particularly like to see increased employer support for?**

**n/a**

**3. What can employers do to ensure multidisciplinary care teams are better supported at the employer level, in terms of specific workplace policies, procedures, or practices?**

The paper identifies (p.19) one 'potential enabler' as follows:

- "Establishing models of multidisciplinary care for target patient cohorts which identify the patient need, the activities required to meet this need and roles and scope for different members of the care team. Cohort-based teams are established for particular conditions, such as diabetes and cancer care, in Australia and elsewhere. It is critical that trust and responsibility for care are appropriately shared across the team and that all members understand and respect each other's qualifications and competencies."

We support this, and suggest that this model is particularly applicable to hard-to-diagnose cancers, such as blood cancers.

The Leukaemia Foundation also has a new 'more eyes on the patient' care model for activating health care professionals (apart from GPs) in rural, regional and remote settings in order to increase community awareness through education of primary healthcare workers other than a GP. This approach is needed to help reduce the blood cancer burden, noting that blood cancers can be difficult to identify, and employer support is critical to enable this to occur. Tellingly, employer resistance would be a significant barrier to this being achieved and delivering benefits to patients.

As described in blood cancer Optimal Care Pathways documentation, **all those involved in cancer care should read and understand the optimal care pathways.** This includes haematologists, radiation/medical oncologists, general practitioners, allied health professionals, nurses and managers of cancer services, along with others in the community sector and government. These pathways guide all practitioners from trainees to highly skilled specialists.

# Education and training

1. What are the key barriers health professionals experience in accessing ongoing education and training or additional skills, authorities or endorsements needed to practice at full scope? You may select multiple responses.

- ○ Availability of learning institutions
- ○ Employer support for learning
- ○ Availability of supervision and mentoring
- ○ Quality of training
- ○ Time burden
- ○ Other

**n/a**

3. To what extent do you think health professionals' competencies, including additional skills, endorsements or advanced practice, are recognised in their everyday practice and are known to consumers?

**n/a**

4. How could recognition of health professionals' competencies in their everyday practice (including existing or new additional skills, endorsements or advanced practice) be improved?

**n/a**

# Funding policy

1. Are you aware of specific instances where funding and payment could be provided differently to enhance health professionals' ability to work to full scope of practice? Please provide specific examples.

**n/a**

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**2. Which alternative funding and payment type do you believe has the greatest potential to strengthen multidisciplinary care and support full scope of practice in the primary health care system?**

- [ ] Block funding
- [ ] Bundled funding
- [ ] Blended funding
- [ ] Capitation
- [ ] Salary
- [ ] Program grants
- [ ] Other
- [ ] None

**n/a**

**3. How do you believe your selected funding type(s) could work to resolve barriers to health professionals working to full scope of practice?**

**n/a**

**4. To what extent do you believe alternative funding policy approaches create risks or unintended consequences?**

- ○ To a great extent
- ○ Somewhat
- ○ A little
- ○ Not at all

**n/a**

**5. How do the risks of alternative funding policy approaches compare to the risks of remaining at status quo?**

**n/a**

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# Technology

**1. How do you think technology could be used better or differently in primary health care settings to enable health professionals to work to full scope?**

Distance to blood cancer specialists and/or hospitals means an increased reliance on high quality primary healthcare for both diagnosis and post-treatment. Patients living outside metropolitan centres in particular are restricted in their access to practitioners.

Telehealth can be better utilised to deliver better outcomes for patients, particularly those in rural, regional and remote communities. Enabling health professionals to use a variety of telehealth approaches can help both patients and those healthcare professionals work to their full scope of practice. As articulated in the blood cancer Optimal Care Pathways:

- "Telehealth can enable efficient shared care and should be explored for all patients. Patients in some rural or remote locations may access specialists via Medicare Benefit Scheme funded telehealth consultations. General practitioners working in rural or remote locations should be aware of specialist multidisciplinary teams with facilities to reduce the travel burden and costs for patients."[i]

- "In a setting where no haematologist is locally available (e.g. regional or remote areas), some components of less complex therapies may be delivered by a general practitioner or nurse with training and experience that **enables credentialing and agreed scope of practice within this area.** This should be in accordance with a detailed treatment plan or agreed protocol, and with communication as agreed with the medical oncologist or as clinically required."[ii]

The Leukaemia Foundation is about to trial a new "Rural, Regional and Remote Program" that will help demonstrate the benefits of using technology to help patients and facilitate health professionals to work at their full scope of practice (without additional professional development burden). Program elements will include:

1. Increase community awareness through education of primary healthcare workers, other than a GP.
2. Development of a decision-making tool to support GP decision making and enable automated alerts for GPs when a patient presents with blood cancer symptoms.
3. "Phone a Friend" specialist haematologist advice for primary healthcare practitioners who have identified the possibility of blood cancer.
4. Creation of a Blood Cancer Wellness Program that provides patients with information and evidence informed practices for living well with blood cancer.

Program delivery will be shared with our project partners, who have formally agreed to partner with us and assist in delivery of the pilot – the Royal Flying Doctors Service, Health Share, and the ACT Government.

This new approach to regional, rural and remote care will improve symptoms awareness and survivorship interventions, thereby leading to prompt diagnosis, referral to appropriate care, and for people to live well beyond a blood cancer diagnosis. With government support, we would be able to trial this at multiple trial sites and eventually expand it to other cancers.

This proposal will help support delivery of the Australian Cancer Plan which, like our proposal, has a strong focus on non-metro areas and equitable health outcomes. The ACP calls for innovative models of care including digital health and navigation, improving access to cancer care, and building the capability of the primary care workforce, e.g.:

- "Improve equitable access to evidence-based, innovative models of integrated multidisciplinary care across the cancer continuum" (Action 3.5.3)
- "Expand access to digitally enabled cancer care to improve equity and access to quality cancer care, particularly in regional, rural and remote areas" (Action 4.5.2)

Decision-support technology also already has the endorsement of key government policy documents. For example, under the National Medical Workforce Strategy, "stakeholders will collaborate to consider where **incorporating decision support software into clinical systems may assist generalists to practise safely with expanded scope**, and to ensure the development of software and algorithms that accurately reflect safe, evidence-based clinical guidelines and treatment pathways, and continuing referral of patients to more specialised care when appropriate."[iii]

**2. If existing digital health infrastructure were to be improved, what specific changes or new functions do you think are most necessary to enable health professionals to work to full scope?**

**n/a**

**3. What risks do you foresee in technology-based strategies to strengthen primary health care providers' ability to work to full scope, and how could these be mitigated?**

Privacy, security and where to deploy the technology-based strategy.

Medical information is sensitive and appropriate controls will need to be in place to safeguard that information.

Data on the workforce is not collected, therefore there is not a clear picture on where haematologists work, what diseases they are treating, when they entered the workforce, and when they are expected to retire. As there has been no workforce planning, there is no understanding of whether there is an under-supply or over-supply of staff and where they are needed geographically.

[i] *Optimal care pathway for people with chronic myeloid leukaemia*, p.10: https://www.cancer.org.au/assets/pdf/chronic-myeloid-leukaemia-1st-edition#_ga=2.199474030.1976630589.1659924132-1517087287.1653444068

[ii] *Optimal care pathway for people with chronic myeloid leukaemia,* p.33: https://www.cancer.org.au/assets/pdf/chronic-myeloid-leukaemia-1st-edition#_ga=2.199474030.1976630589.1659924132-1517087287.1653444068

[iii] https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf