PRACTICE DEVELOPMENT MATRIX

Continuous Quality improvement (CQI) is all about implementing a series of small changes to your processes that will add long-term value to your practice.

The 10 Building Blocks of High Performing Primary Care outlines the key processes that primary care providers need to implement to make sure their practice is performing well. The Brisbane North PHN Practice Development Framework breaks the 10 blocks into three focus areas for improvement: **Process** Improvement, **Data** Improvement and **Patient Health Outcomes** Improvement.

The table below outlines the improvement areas and describes what activities or processes are involved. This is then mapped to the RACGP standards. Also included in the table are links to available resources and suggested continuous quality improvement activities that practices could implement. This resource is designed to be tailored to your practice and your patient cohort. You can use this matrix to plan CQI initiatives, to develop your practice goals or to plan your staff training and meeting agendas.

BUILDING BLOCK	WHAT DOES THAT MEAN?	WHAT ACTIVITIES OR PROCESSES ARE INVOLVED?	WHICH RACGP STANDARD DOES IT ALIGN TO?	PHN OR OTHER RESOURCES AVAILABLE	QUALITY IMPROVEMENT ACTIVITY (CQI) IDEAS
PROCESS IMPROVEMENT					
Engaged Leadership	Practice has clear goals, objectives and priorities. Practice leaders are engaged in the change. Practice has a documented quality improvement plan. Leaders at all levels of the business (GP's RN and Reception staff) understand and support practice goals.	Set practice goal and objectives. Identify, support and develop the team. Improve practice work environment to ensure staff well-being and limit staff turn-over. Manage risks and develop contingency plans Invest in improvements/technologies to streamline work practices and staff well-being Develop practice policies and procedures	Core Standard 3.1 Core Standard 3.2 Core Standard 3.3 Core Standard 3.4 Core Standard 3.5 Core Standard 3.6 Core Standard 6.4 Core Standard 8.1 QI Standard 1.1 QI Standard 3.1	CQI Year Activity tracker Micro-Video 7 – Quality Improvement Overview Micro-Video 4 – Human Resources Micro-Video 6 – Leadership in Practice Micro-Video 1 – Pandemic Planning Micro-Video 3 - Supporting Staff in a time of Crisis	Session to develop and/or share practice vision, mission, goals and objectives Brainstorming, discussions, and planning sessions in staff meetings Staff training and development to understand why the initiative is important Develop a calendar of CQI plans for the year will all staff input Develop a risk management strategy Develop disaster recovery policies and plans
Patient Registration	Identify your patient population and their needs. Create relationships with your patients by linking patients to a provider.	Identify your patient group. How are you going to improve your patient's health outcomes? No new patients for overloaded doctors?		MyMedicare resources ABS Statistics By Region Brisbane City Council Population Profile Reports	Brisbane City Council Population and Australian Bureau of Statistics reports for data about of local population Tracking and improving patient MyMedicare registration numbers Quality improvement activities to improve patient outcomes Clear communication of MyMedicare process and benefits to staff and patients
Population Management	Ideally, patients will visit the same practice and the same provider. This reduces hospital visits, overall costs on the health system and costs to the practice. Too many complex patients can lead to GP burnout.	Share workload amongst providers Identify GPs with special interests Monitoring systems for patients who have not come in but should have for screening or monitoring appointments Appointment booking workflows Eliminate processes, equipment and stock that are not needed or add no value Reduce repeat visits resulting from 'missed' work (e.g. scripts and referrals)	QI Standard 1.2 GP Standard 5.1	Appointment Booking Requirements example	Simplify and document booking processes to reduce double booked or incorrect appointments Streamline and standardise recall and reminder activities. Monitoring of patients who should be attending for follow up but have not Checklists for GP's to use during consultations (check for scripts coming due, referrals etc) so appointments are proactive. Optimise appointment notes from reception where possible Schedule RACH visits to ensure all patients are seen regularly, 2 care planning activities are done per year and to optimise time spent on site. Optimise equipment, inventory, and processes to avoid wasting time and resources. Discard anything that does not add value

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					Automation processes as possible using available technologies
Prompt access to care	Patients have access to care when they need it. Reduce the time patients must wait to get an appointment. Reduce the waiting time on the day of their appointment.	GP working hours and work patterns Diary management. Optimisation of available consultation and treatment spaces. Treatment Room workflows. Booking processes (which doctor will do which procedures, how long it takes, who else is needed, what equipment is needed).	GP Standard 1.1 GP Standard 1.2 GP Standard 1.3	Appointment Booking Requirements example	Diary management • GP work hours and patterns • Do you have enough on the day appointments • Consistent triage guidelines for reception staff • Configure online booking calendar effectively to avoid duplication or incorrect appointment bookings • Clarify and document appointment booking processes • Standardise follow up appointment processes • Investigate do-not-attend appointments for patterns • Triage training for reception staff Reduce treatment room set-up and pack-up frequency and time taken. Schedule routine maintenance of facilities and equipment to avoid down time
Template of the future	Change is inevitable. The general practice environment is changing. There is an increased need for data, a focus on ongoing quality improvements, a move to team based care and a constant desire for better outcomes at lower costs.	Future proofing activities, technical advancements, and innovations. Ongoing quality improvement. Changing appointment modalities (video and telehealth). Fewer but longer in-person visits is the goal. Clinicians moving from the sole provider to mentor and clinical team leader.	QI Standard 1.1	Micro-Video 5 – Change Management Micro-video 12 – 10 Building blocks of high performing primary care	Clarify and document all business processes Look at technical advances available and trial/implement as appropriate Consider how GP's can best spend their time and reduce, reallocate, or remove busy work that has little benefit. Add process, data, and patient health outcome improvement ideas to all meeting agendas
DATA IMPROVEMENT					
Data driven improvement	Know your patient population Identify your populations needs	What data does your practice use. Ensure your data is clean. Identify and understand your patient population (collect baseline data). Collect clinical, operational, and patient experience data using a variety of tools. Data policies and procedures	PIP QI 10 QIM's Accreditation metrics Core Standard 6.1 Core Standard 6.2 QI Standard 1.3	Primary Sense manuals Micro-video 7– Quality Improvement Overview Micro-video 8 – Practice Incentive Program (PIP QI)	Improve your data quality: • Deactivate inactive patients • Remove duplicate patients • Check consistency of condition coding • Update new patient information form to add new data fields • Form for existing patients to update/capture new data • Check in kiosk or online information update Use primary sense to: • Identify patient populations • Data completion report for upcoming patient visits Other forms of data collection, clinical software, patient satisfaction survey Review the data. Provide outcomes of care data to practice staff routinely Move policies and procedures online so all staff can access them easily.
PATIENT HEALTH OUTCOMES IMPROVEMENT					
Team Based care	GP's coordinate care but who can help? Case conferences, shared care and other health professionals reduce pressure on GP's	Develop care teams/cooperative relationships both inside and outside of the practice. Consider best use of internal resources – Nurse Practitioner, Registered Nurses, Aboriginal and Torres Strait Islander Health Practitioner, Aboriginal Health Worker, practice staff etc. Consider best use of external resources – residential aged care home staff, pharmacists, allied health, specialists and other services. Clinical records are detailed, complete and common coding and recording practices are in place	Core Standard 8.1 QI Standard 1.3 QI Standard 2.1 QI Standard 2.2 GP Standard 3.1		What tasks do GP's currently do that another team member could do (e.g. visual acuity, urine testing, ECG's, hearing testing, health assessments). Any training required? Use patient data for patient outreach and pre-visit planning Reception manages recalling patients for appointment, care plans, HA, MHTP, HA and reviews, RN's – focus on care planning, preventative health, and lifestyle advice activities Work with residential aged care home staff effectively streamline processes and care planning Workflow analysis to streamline processes and clarify care team roles

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					Standing orders for RN's for patients with ongoing wound care Standard coding and recording systems for patient records
Patient-team Partnership	Improve health literacy and agency of patients. Health equity – equal access and outcomes for all patient populations. Patient should be active partners in their health care and at the centre of all decision making.	Provision of comprehensive, guideline-based Information for patients about their health, conditions and available services Information available for all patients including languages other than English, resources for the hearing and vision impaired, pitches at an appropriate level Health system navigation assistance Get information from patients about their preferences, values and wishes. Document this information.	Core Standard 1.1 Core Standard 1.2 Core Standard 1.3 Core Standard 1.5 Core Standard 2.1 Core Standard 2.2 Core Standard 2.3 Core Standard 6.3 QI Standard 2.2 QI Standard 3.2	Practice support website Health in my language Refugee ready practice checklist RACGP Refugee Health Module TIS Info sheets and welcome pack coming soon Health Resources Directory Health Pathways/Care Collective	Provide appropriately targeted health information for patients in a range or locations and delivery methods (print, website, social media): • Flyers • Posters • Information brochures • Waiting room TV/Social media tiles • Celebrate with health weeks and link into other services or promotions Staff training on available prevention, information and support programs Seek info about patients' preferences, values and wishes. Document this information Flag patient's needs (e.g. interpret, translator, transport assistance) on their patient and clinical record and get feedback from patient about if these services were successful.
Continuity of Care	Patients requiring interpreters, with complex care needs or on more than 5 medications can be very difficult.	Consider GP's patient load and adjust Training front-desk staff in the importance of continuity of care and asking who the patients usual GP and care team is.	Core Standard 1.4 Core Standard 4.1 Core Standard 5.1 Core Standard 5.2 Core Standard 5.3 Core Standard 7.1		Categorise high needs patients to share the load among practice GP's Regular/routine checking of results and report (especially when doctors are on leave) Locate patients with care gaps and address key issues Care planning, medication reviews, health coaching and prevention activities
Comprehensiveness and care coordination	Our ageing population, chronic conditions and lifestyle factors are causing an increased need for coordinated care. GP's should provide most of what the patient needs or, coordinate with specialists, pharmacists, hospitals, residential aged care homes etc.	Record all family history, social circumstances, diagnosis, medication, history and preferences in patient record. Focus on preventative care, coordinated care for acute illness and long-term conditions and end of life care.	GP Standard 2.1 GP Standard 2.2 GP Standard 2.3 GP Standard 2.4 GP Standard 4.1 GP Standard 5.2 GP Standard 5.3 GP Standard 6.1	Micro-video 2- Infection Control	Offer flu, COVID and other vaccinations opportunistically to all patients Undertake an audit of patients at crucial ages, with chronic conditions and at key health care transition stages. Develop and implement strategies to identify patients and ensure continuity of care Nominate care coordinator in the practice to monitor patients with chronic disease but no care plan or those at risk of hospitalisation Work with RACH staff to patients at risk of hospitalisation and planning for end of life Improve preventative and chronic care and link to community resources and services. Health awareness campaigns, screening campaigns, care planning.