# 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 Practice Digital Health 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.

**Remember** –

| **BUILDING BLOCK** | **WHAT DOES THAT MEAN?** | **WHAT ACTIVITIES OR PROCESSES ARE INVOLVED?** | **WHICH RACGP STANDARD DOES IT ALIGN TO?** | **PHN OR OTHER RESOURCES AVAILABLE** | **CONTINUOUS 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](https://partners4health.sharepoint.com/%3Aw%3A/r/programs/PrimaryCareLiaison/_layouts/15/Doc.aspx?sourcedoc=%7B6F7A2A86-D350-4DD4-96C3-E3EDCDE4525E%7D&file=FIN_BNPHN_CQI-Yearly-Planner-V22024.docx&action=default&mobileredirect=true)  [Accreditation worksheet](https://partners4health-my.sharepoint.com/personal/jennifer_roush_brisbanenorthphn_org_au/Documents/Documents/2%20CQI/Templates/Accreditation%20Worksheet.xlsx)  [Risk management template](https://partners4health-my.sharepoint.com/personal/jennifer_roush_brisbanenorthphn_org_au/Documents/Documents/2%20CQI/Templates/Accreditation%20Worksheet.xlsx)  [Micro-Video 9 – Quality Improvement Overview](https://www.youtube.com/watch?v=W3Wd98ruSpQ)  [Micro-Video 5 – Human Resources](https://www.youtube.com/watch?v=SjQ3HqI45w4) [Micro-Video 8 – Leadership in Practice](https://www.youtube.com/watch?v=KS-7ilCziF0) [Micro-Video 1 – Pandemic Planning](https://www.youtube.com/watch?v=_2wS-fUDQAg) [Micro-Video 3 - Supporting Staff in a time of Crisis](https://www.youtube.com/watch?v=qoXteE86J6s)   | 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 and their cultural and ethnic backgroundsDo your patients require an interpreter or other assistance? How are you going to improve your patient’s health outcomes?  No new patients for overloaded doctors?   | Core Standard 1.4Core Standard 2.1Core Standard 2.2Core Standard 2.3 | [MyMedicare resources](https://practicesupport.org.au/toolbox/medicare-dva/mymedicare) [Translating and Interpreting Service](https://www.tisnational.gov.au/) [Tips and Tricks for working with an interpreter](https://www.youtube.com/watch?v=tx7Zotoe2Qo)[Working with patients where there are language barriers](https://practicesupport.org.au/web/assets/images/Working-with-patients-when-there-are-language-barriers_DIGITAL.pdf) (TIS set up and usage guide)   | Brisbane City Council Population reports for background 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 Register for Translating and Interpreting Service (TIS) and train all staff in how to use itRecord the ethnicity of patients, preferred language, country of birth and if they need an interpreter in your clinical software. Update your new patient information form to capture this information.Cultural competency, cultural awareness and cultural responsiveness training for staffDiscuss the cultural and ethnic profile of your patients and the implications for patient care at staff meetingsProvide health resources in languages other than English  |
| 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 GP;s 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 (eg scripts and referrals)    | QI Standard 1.2 GP Standard 5.1  | [Booking Processes Document](https://partners4health-my.sharepoint.com/personal/jennifer_roush_brisbanenorthphn_org_au/Documents/Documents/8%20Merthyr/Appointment%20booking%20worksheet.xlsx)     | 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 haven’t   Checklists for GPs 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  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  | [Booking processes document](https://partners4health-my.sharepoint.com/personal/jennifer_roush_brisbanenorthphn_org_au/Documents/Documents/8%20Merthyr/Appointment%20booking%20worksheet.xlsx)   | 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 6 – Change Management](https://www.youtube.com/watch?v=BZPDHwExD4Y)  [Micro-video 12 – 10 Building blocks of high performing primary care](https://www.youtube.com/watch?v=KUTyMQgBd4Q)    | 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** **AND PRACTICE DIGITAL HEALTH** |
| Data driven improvement   | Know your patient population  Identify your populations needs Use available digital health tools to support business operations and improve patient outcomes    | 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 Set up and effectively use digital health tools to improve access and availability of patient’s health information. Standardise and streamline clinical record keeping ensuring that GP’s have all the information they need to make clinical decisions Implement and meaningfully use a range of programs and tools to streamline prescribing of medication and referrals to other healthcare providers Understand, implement and document data and messaging security processes and technologies  | PIP QI 10 QIM’s Accreditation metrics  Core Standard 6.1 Core Standard 6.2 QI Standard 1.3 Core Standard 5.1Core Standard 6.2Core Standard 6.3Core Standard 6.4Core Standard 7.1QI Standard 2.1GP Standard 2.1GP Standard 2.2GP Standard 2.3GP Standard 2.4 | [Primary Sense manuals](https://www.primarysense.org.au/resourcesandmanuals/manuals)  [Micro-video 7– Quality Improvement Overview](https://www.youtube.com/watch?v=EftGaDDknIw)   [Micro-video 10 – Practice Incentive Program (PIP QI)](https://www.youtube.com/watch?v=m2KXijVCZGg)  Digital Health Checklist (coming soon)  | 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 surveys, inventory management and accounting software. Review the data.  Provide outcomes of care data to practice staff routinely  Move policies and procedures online so all staff can access them easily. Installation and use of Primary Sense, PRODA/HPOS, MyHealth Record, National Cancer Screening Register, MyMedicare, Health Provider Portal/Viewer, Australian Immunisation Register and other disease management programs and softwareSet up and use Secure Messaging, ePrescribing and Qscript, GP Smart Referrals, Metro North Electronic Referral Templates and Kiteworks .Set up and use telehealth and video conferencing tools Set up and use clinical decision support systems to help clinicians make evidence-based decisions by integrating patient data and medical histories as well as evidence-based guidelines Integrate your practices system with health information exchanges to allowing the sharing of health information between healthcare providers to improve care coordination. Implement standard condition coding processes and procedures.Develop policies and procedures around data and cyber security. Implement systems to prevent data breaches. Include data and cyber security procedures in your Emergency Management, Business Continuity and Information Recovery Plans. Regularly review policies and processes. Train practice staff in prevention, detection and reporting of data and cyber security breaches. |
| **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 – RACH 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 (eg visual acuity, urine testing, ECG’s, hearing testing, health assessments). Any training required?  Use patient data for patient outreach and pre-visit planning   Reception manage recalling patients for appointment, care plans, HA, MHTP, HA and reviews, Practice Nurses – 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   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](https://practicesupport.org.au/)  [Health in my language](https://www.mcwh.com.au/project/health-in-my-language/)   [Refugee ready practice checklist](https://practicesupport.org.au/web/assets/images/Refugee-Health-Ready-Practice-Checklist-April2022.pdf)   [RACGP Refugee Health Module](https://www.racgp.org.au/education/education-providers/curriculum/curriculum-and-syllabus/units/migrant-refugee-and-asylum-seeker-health)  [Health Resources Directory](https://healthresourcedirectory.org.au/en/)  [Health Pathways](https://brisbanenorthphn.org.au/practice-support/the-healthpathways-program)/[Care Collective](https://brisbanenorthphn.org.au/our-programs/team-care-coordination-program) [Health Literacy Resources in Languages other than English](https://www.healthtranslations.vic.gov.au/) | Provide appropriately targeted health information for patients in a range of locations, languages 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 information about patients’ preferences, values and wishes.  Document this information  Flag patient’s needs (eg 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  | [Forum of Australian Services for Survivors of Torture and Trauma](https://www.fasstt.org.au/)[QPASTT (Queensland Program of Assistance to Survivors of Torture and Trauma)](https://qpastt.org.au/)[Inclusion of communication time when claiming time tiered MBS items](https://mbsonline.gov.au/internet/mbsonline/publishing.nsf/Content/F66C9FB73B5FCFC6CA25882900003240/%24File/FS-Managing-challenges-communication.06.06.22.pdf)[Multicultural Health Coordination Program](https://www.mater.org.au/health/services/refugee-health/multicultural-health-coordination-program) | Categorise high needs patients to share the load among practice GPs  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 Training and information session for GPs on how to work with interpreters, how to bill for the consultation when extra communication time is needed dueTraining and information session for clinical staff about the programs available to support and assist people from refugee and multicultural backgrounds. |
| 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](https://www.youtube.com/watch?v=dEmAxfhAfp4)     | 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 identify 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.  |