Collaboratives Practice Checklist

Chronic Disease + Access & Care Redesign

This checklist has been developed to assist Division staff in providing effective support to practices participating in the Australian Primary Care Collaboratives (APCC) program.

The checklist is based on knowledge gained by Divisions and practices during the course of the program and the APCC Collaborative Handbook. It incorporates a list of ideas to consider rather than a list of steps that must be completed.

The clinical software ideas are based on Medical Director in conjunction with either the PENT CAT or the Canning tool. The checklist may require adaption when used in practices with other clinical software.

The CPM Notes section, Part 2 of this checklist, gives additional information on terminology, measures and change principles.

The Practice Details table is intended to collect key practice information which will be useful when interpreting practice graphs and assist in continuity of care for the practice in the event of a Division staff change.

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Practice Details

Practice Name:	Contact:
APCC Wave:	Reason for Joining APCC:
Clinical Software:	Front Desk Software:
Extraction Tool:	Version:

GP No:	GP FTE:	PN No:	PN FTE:	Staff No:

Accredited: Y N	Clinical Meetings: Y N	Staff Meetings: Y N

Register Manager:	Position:
Access & Care Redesign Lead:	Position:
Chronic Disease Lead:	Position:

Practice Days: M T W Th F S S	Closed Books: Y N	Open Access: Y N

	Jan	Mar	Jun	Sep	Dec	Mar
Practice Capacity:Demand Ratio						
Total Patients in Practice (From Clinical Software)						
Average Age of Patients (From Clinical Software)						

System specifications

PEN CAT	Canning Tool
• Medical Director, Best Practice, Genie	• Medical Director 2, Medical Director 3, Best Practice, Medical Spectrum, Practix, MedTech 32
• Operating System: VISTA, XP or 2003	• Operating System: VISTA, XP or 2003
• Microsoft .NET Framework installed	
• Internet Explorer version 5.5 or later	• Internet Explorer 7 in order to show graphs automatically
• Internet Connection required for auto upload	• Internet Connection required for e-mailing /auto upload
• 196MB of available memory	• 1GB RAM memory
• 25MB of disk space	

Change Principles & Change Ideas

Access & Care Re-design	Diabetes	Coronary Heart Disease
1. Building the Practice Team	1. Building the Practice Team	1. Building the Practice Team
• Set realistic goals • Communicate with other team members • Engage the practice team • Assign roles and responsibilities • Reflect & review what you are doing	• Set realistic goals • Communicate with other team members • Engage the practice team • Assign roles & responsibilities around diabetes management • Reflect & review what you are doing	• Set realistic goals • Communicate with other team members • Engage the practice team • Assign roles & responsibilities around CHD management • Reflect & review what you are doing
2. Foundation Work 2.1 Know your business 2.2 Change your business	2. Establish a system for creating, validating and updating a register of people with diabetes	2. Establish a system for creating, validating and updating a register of people with CHD
• Know your business o Understand current capacity of the practice o Understand the profile of demand • Change your business o Communicate with staff and patients o Shape the handling of demand o Shape patient behaviour o Match the capacity of the team to the reshaped demand o Embed and monitor the system o Contingency plan	• Agree on a clear definition of diabetes type 1 and diabetes type 2 • Develop a register of people with diabetes • Develop systems to maintain a valid register	• Agree on a clear definition of CHD • Develop a register of people with CHD • Develop systems to maintain a valid register
3. Pathways	3. Be systematic and proactive in managing care	3. Be systematic and proactive in managing care
• Advanced access • Managing demand • Increasing capacity • Increasing quality	• Establish systems for delivering care to patients with diabetes • Establish appropriate care pathways for people with diabetes • Establish proactive call and recall arrangements for people with diabetes • Use guidelines, protocols and computer templates to support care delivery	• Establish systems for delivering care to patients with CHD • Establish appropriate care pathways for people with CHD • Establish proactive call and recall arrangements for people with CHD • Use guidelines, protocols and computer templates to support care delivery
	4. Involve patients in delivering and developing their care	4. Involve patients in delivering and developing their care
	• Implement a deliberate strategy for self-management • Integrate the patient's perspective constantly in the design of services • Ensure written and verbal communication is appropriate and understood • Pay special attention to the needs of people from hard to reach groups • Identify psychosocial factors which may affect patient care	• Implement a deliberate strategy for self-management • Integrate the patient's perspective constantly in the design of services • Ensure written and verbal communication is appropriate and understood • Pay special attention to the needs of people from hard to reach groups • Identify psychosocial factors which may affect patient care
	5. Develop effective links with key local partners	5. Develop effective links with key local partners
	• Analyse the patient journey and redesign where necessary • Identify and engage local organisations and other sources of care in developing diabetes services • Provide integrated care by improving the relationship between primary, secondary and tertiary providers	• Analyse the patient journey and redesign where necessary • Identify and engage local organisations and other sources of care in developing CHD services • Provide integrated care by improving the relationship between primary, secondary and tertiary providers

Chronic Disease Checklist

TASK	COMMENTS	
Software Training		
Clinical Software		
Data Extraction Tool		
Web Portal		
CHANGE PRINCIPLE 1: BUILDING THE PRACTICE TEAM		
See Access and Care Redesign Change Principle 1		
CDM CHANGE PRINCIPLE 2: CREATE, VALIDATE AND MAINTAIN REGISTERS		
Archiving	Before	After
Practice has archived non-current and deceased patients		
Reception staff ask patients if they have been to the practice before and can reactivate archived patients		
Patients are marked as deceased with a valid date: DD/MM/YYYY		
Pathology Results		
Practice receives electronic pathology results in HL7 LOINC format		
Electronic results routinely actioned by all GPs		
Effective Data Entry		
Diagnoses are always entered in 'Past History' using codes		
Free text diagnoses in Past History has been converted to code		
Blood pressure readings are always entered "in a box"		
Medications, including 'over the counter' medications are entered in current medications		
"Reason for contact" and "Reason for medication" prompts are enabled		
MI entered with a valid date : DD/MM/YYYY		
PMH is unticked when subsequent medications are prescribed for MI		
Identify Patients – Pathology Results		
Compare pathology list of patients referred for HbA1c with register to identify patients with diabetes		
Use Webster to routinely download HbA1c lists		
Identify Patients - Database Searches		
IHD added to all CHD diagnoses to provide 'umbrella' term		
CHD medication searches performed		
Diabetes medication searches performed		
Diabetes / CHD overlap database searches performed		
MI medication and chest pain database searches performed		
Hybrid Practices – Enter Data From Hard Files		
Diagnoses and clinical data from hard files entered on clinical software		
Patient Managed Elsewhere		

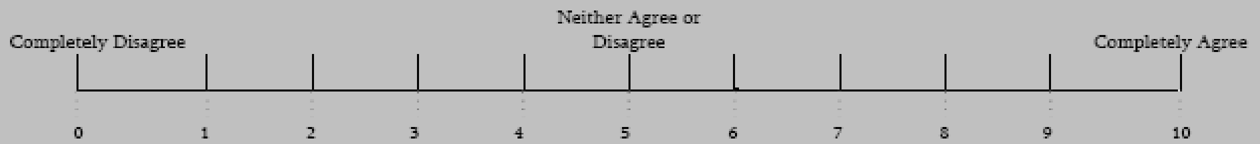
Specialists requested in referral letters to add GP in 'Copy Dr' section of pathology referrals – allows delivery of pathology results in HL7 format.	
Data from specialist letters entered in correct fields in clinical software	
Maintain Registers	
Register Manager nominated and trained	
CDM CHANGE PRINCIPLE 3: BE SYSTEMATIC AND PROACTIVE IN MANAGING CARE	
Recall Systems	
Only current recalls are on the database	
Recall terms are agreed by practice	
Recall letter templates match recall terms	
Recall letters are personalised for each patient and compare current results with national guidelines	
Recalls scheduled for 'low demand' appointment times	
GPs delete Recalls when performed and set new ones as required	
Outstanding Actions	
Outstanding Actions enabled	
Only current Actions are on the database	
GPs delete Actions when performed and set new ones as required	
CDM Items	
'Comments' function used to remind GPs about CDM Item content	
All CDM items coded as a condition – enables database searches	
CDM templates loaded on clinical software	
SIPs	
All GPs in accredited practices have signed PIP/SIP Part G form to access SIP payments	
CDM CHANGE PRINCIPLE 4: INVOLVE PATIENTS IN DELIVERING AND DEVELOPING THEIR CARE	
Practice encourages 'Patient Held Records'	
Patients have a personalised care plan	
Patients receive self management training	
Patients are aware of local support services	
Practice uses Patient Education Leaflets to help the patient understand their condition (many leaflets can be found in clinical software)	
CDM CHANGE PRINCIPLE 5: DEVELOP EFFECTIVE LINKS WITH KEY LOCAL PARTNERS	
Practice has a directory of local service providers Practice address book is up-to-date	
Local support groups are advertised in the practice	
Practice delivers community education days in conjunction with local service providers	
Practice staff attend local meetings	

Access Checklist

TASK	COMMENTS
ACCESS MONTHLY MEASURES	
Survey – Patient satisfaction with appointment system Sample Size: 50 patients over 1 week each quarter *'I was able to get an appointment with the person I wanted on the day I wanted.'*	
10 patients per day are asked to complete survey - 5 patients complete survey in the morning and 5 in the afternoon	
To reduce bias the survey is completed before the patient sees the GP	
Survey results are collected anonymously	
Unmet Demand – The number of patients who choose not to wait for an appointment or who cannot get an appointment	
Tally the number of people over one week each month who want to make an appointment but do not end up doing so.	
The number of days until the GP & nurse 3rd available appointment This measures the availability of **routine** appointments for the **practice.**	
During the month the measurement is taken on **one day** in **each week** – called the **measurement day**.	
The **measurement day** is **rotated** each week: Monday during Week 1, Tuesday during Week 2, etc. This gives a better overall picture of the whole month's activity.	
The FTE status of each GP and nurse is entered in the spreadsheet 40 hours = 1 FTE (based on 10 x 4 hour sessions per week). The spreadsheet automatically calculates a pro rata measure.	
When a GP or nurse is sick for more than 3 days and the sessions are not covered by locums an 'S' is entered in the spreadsheet for that week	
When a GP or nurse is on holidays for more than 3 days and the sessions are not covered by locums an 'H' is entered in the spreadsheet.	
Only **routine** appointments are used for calculating the measure i.e. not gaps in a 'book on the day' section of the appointment book	
Practices who will not get a valid result from the 3rd available appointment measure	
• Practices that do not take appointments (e.g. Open Access practices) • Appointment systems that are 'book on the day' only (where patients are not allowed to book in advance) • Appointment systems that are 'de facto book on the day'. i.e. patients can only book ahead a certain length of time (e.g. one week into the future). In this case, you can only calculate the 3rd available appointment for the week, and the results will be artificially low	

We are assessing how easy it is to get an appointment on the day you wanted with the doctor or nurse you wanted. Please think about today's appointment and rate your agreement with the statement below:

'I was able to get an appointment with the person I wanted on the day I wanted.'
(Please circle one)



Microsoft Excel - Phase II_Monthly_Measures_Worksheet_Final

File Edit View Insert Format Tools Data Window Help

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	A	B	C	D	E	F
1		**GP 3rd Available Appointment Calculator**				
2						
3		**Month:**	**January 2009**			
4						
5		**GP Number:**	**1**	**2**	**3**	**4**
6		**GP Name**	Dr Owen	Dr Newland	Dr Streeter	
7		**FTE**	0.8	1	0.2	
8	**Week 1**	24/08/2009	3	2	3	
9	**Week 2**	1/09/2009	2	3	1	
10	**Week 3**	9/09/2009	1	2	3	
11	**Week 4**	17/09/2009	3	2	3	
12						
13		**Total**	9	9	10	0
14		**Average**	2.25	2.25	2.50	
15		**Av X FTE**	1.80	2.25	0.50	
16						
17						
18		**Days to Third Available:**		2.275		
19						
20						
21						
22		**Instructions**				

Resources Available from APCC 'My Site' Type **'third available spreadsheet' in the search box**

CHANGE PRINCIPLE 1: BUILDING THE PRACTICE TEAM	
SET REALISTIC GOALS	
Goal Setting Establish why the practice joined the Collaborative program e.g. • Access to a range of ideas on how to develop service delivery to best shape and meet demand • Assistance in ensuring the team is working effectively, efficiently and with increased satisfaction • Decrease stress and burnout • Remove or reduce patient waiting times • Provide the capacity for focussing on better chronic disease management	
Goal 1:	
Goal 2:	
Document the benefits for patients and staff from participation in the program e.g. Patient focussed services and increased job satisfaction	
Patients:	
Staff:	
List measurable and achievable practice goals ***Remember: each patient should get the care that most benefits them – this program is not about getting 100%!*** e.g. GP 3rd Available appointment = 1 day e.g. 60% of diabetes patients have an HbA1c ≤ 7% e.g. 50% of CHD patients have an BP < 140/90	
Access Goal:	
Diabetes Goal:	
CHD Goal:	
Team Health Check completed and analysed	**Ratings**
Goal Setting	
Team Engagement	
Roles and Responsibilities	
Communication	
Reflecting and Reviewing	

COMMUNICATION WITH OTHER TEAM MEMBERS	
Clearly communicate to the team: • Reason why practice has joined the Collaboratives • Benefits to patients and staff • Practice goals	
Meetings	
Practice holds regular clinical meetings	
Practice holds regular staff meetings	
Information flows between clinical and staff meetings	

Practice holds regular meetings offsite, ensuring protected time	
Meetings are supported with agendas, minutes, rotating chair, standing items for common issues, schedule for meetings	
Teams are trained in good meeting practice: e.g. respect, preparedness, timeliness, accountability	
Team members are aware of their roles, responsibilities, commitments and requirements of the APCC program	
Communication Channels	
Notice boards	
Emails	
Intranet	
Communication Book	
ENGAGE THE PRACTICE TEAM	
Team led by practice principal or APCC champion	
Team understands why change is important	
Team is involved in developing and implementing ideas	
All staff feel their input is valued (obtaining individual perspectives)	
All staff are treated with courtesy at all times	
Practice values and ethics are clearly communicated	
ASSIGN ROLES AND RESPONSIBILITIES	
Written job descriptions include roles and responsibilities	
Performance appraisals are supportive and motivational	
Staff have appropriate skills to complete tasks	
Protected time is provided	
All tasks are assigned	
Everyone is aware of how their tasks affect others	
Contingency plans are in place to cover people on leave	
Tasks are allocated or chosen with a view to achieving outcomes	
REFLECT ON AND REVIEW WHAT YOU ARE DOING	
Outcomes are compared with goals	
Meetings are held to discuss outcomes and barriers	
Success is celebrated	
Team skill mix is evaluated to identify training and recruitment needs	
Training is provided where required	
Patient feedback is incorporated in plans	
Physical environment is conducive to performance	

ACCESS CHANGE PRINCIPLE 2.1 - KNOW YOUR BUSINESS	
UNDERSTAND THE CURRENT CAPACITY OF THE PRACTICE	
Weekly Capacity	
Number of routine appointments available	
Time available for holidays	
Time available for clinic sessions	
Time available for home visits	
Time available for RACF visits	
Time available for training	
Time available for meetings	
Daily Capacity	
Number of routine appointments per day	
Number of 'book on the day' appointments	
Number of appointments for each GP	
Number of appointments for each PN	
Number of appointments for other staff (ie. allied health professionals)	
UNDERSTAND THE PROFILE OF DEMAND	
Try to keep demand at about 90% of capacity	
Demand is measured across the year – peak and regular seasons	
Demand is measured for 3 – 6 weeks to provide an adequate sample	
Requested Appointments	
Number of requests by patients for appointments for each day	
Number of requests for appointments for each clinician	
Number of GP requested follow-ups for each day	
Number of 'booked-on-the-day' appointment requests	
Number of requests for pre-booked appointments	
Number of requests for home visits	
Number of requests for RACF visits	
Number of appointments for scripts	
Number of appointments for referrals	
Type of Demand	
Types of consultations for each clinician: e.g. Follow up, reviews, acute, CDM, mental health, multiple issues	
Number of GP consultations that could have been undertaken by another staff member	
Number of patients seen per day by jeopardy doctor (doctor who only sees patients who book on the day)	
Number of fit-ins	
Number of 'urgent' appointments that are determined by GP as not urgent.	

Backlog (True backlog = bad backlog – good backlog)	
GP and Practice Nurse 3rd available appointment measure	
Backlog calculated: average number of routine appointments per day x 3rd available appointment = Backlog If your 3rd available appointment is 4 days and you offer 30 appointments per day, your backlog is: 4 x 30 = 120 appointments	
OR Number of appointments already in the appointment book at beginning of week for each day	
Number of patients who have to take an appointment in the future when they want an appointment today (Bad Backlog)	
Number of patients who want an appointment in the future (Good Backlog)	
Unmet Demand	
For each day	
For each clinician	
Other Measures	
Patient satisfaction survey	
Number of 'Did not attend' (DNAs)`	
Number of empty appointment slots per day	
Number of unanswered phone calls (Telstra report)	
Division Assistance	
APCC CPM Access worksheets are used	
Division graphs demand vs capacity	
Division graphs daily demand vs GP capacity	
Division graphs daily demand by type of appointment: GP requested follow up and patient requested appointment	
Division graphs Demand profile	

CHANGE PRINCIPLE 2.2 - CHANGE YOUR BUSINESS	
COMMUNICATE WITH STAFF AND PATIENTS	
Everyone affected by the change understands what is happening and why	
Patients and staff are involved in service redesign	
Staff understand demand measures	
Access graphs are pinned on notice boards and discussed at meetings	
Patient surveys, forums or focus groups used	
SHAPE THE HANDLING OF DEMAND	
Practice teams skills and aptitudes are used to maximum effect	
Reception staff use telephone headsets	
When doctors are away patients can only book appointments once the doctor is back – to reduce backlog	
Patients associated needs are met on the day of the consultation	
Computer prompts are used as reminders for patient needs e.g. scripts, referrals	

Patients are encouraged to maximise the consultation e.g. by writing a list of problems to be addressed	
Alternative ways of accessing practice services are used e.g. email, websites and telephone consultations	
Patients see healthcare provider of their choice	
Practice protocol on follow-ups are based on national guidelines	
Practice nurses or Aboriginal health workers provide appropriate care	
Chronic Disease Management (CDM) clinics implemented	
Group education sessions available for patients	
Practice team encouraged to understand the range of other community services that patients could use in collaboration with practice based services e.g. Heart Moves, walking groups, LMP programs, Gyms, patient led self management options	
Chronic disease coordinators appointed to manage: • Clinic systems • Chronic disease MBS items • Annual cycles of care • Recall system • Register cleaning and maintenance • Clinical software data entry requirements • Data extraction and analysis	
SHAPE PATIENT BEHAVIOUR	
Patient self management is encouraged	
Waiting room has range of information and options for self referral services that patients with chronic conditions may choose to use	
Calendars of care are used for patients who attend frequently	
Patients understand practice appointment system e.g. standard appointments, long appointments and the need to request specific appointments when necessary	
Patient educated on the care the practice nurse can provide e.g BP checks, CDM support (10997)	
Patients educated on chronic disease management items, health assessments and medication reviews	
Patients receive copies of their pathology results and understand what they mean	
GPs show confidence in practice nurses and encourage patients to see them	
Patients are contacted to ensure they are alright when they miss an appointment and to educate them on the effect on the practice of DNA's	
Patients understand the need to arrive for appointments on time	
Patients who are new or have long appointments receive reminder calls via phone, email or SMS messages	
MATCH THE CAPACITY OF THE TEAM TO THE RESHAPED DEMAND	
Maximum appointments are available when demand is highest	
Receptionists are trained to become healthcare assistants	

Nurse led clinics available for minor illness, vaccinations and chronic disease management	
Personal development plans are in place for clinicians and staff	
Non clinical staff; • Sterilise equipment • Maintain vaccine fridges and cold chain • Clean registers • Maintain recall system • Order patient self management education resources • Stock the waiting room (patient lounge) with healthy literature • Promote health events e.g Diabetes Week	
Volunteer 'expert' patients with chronic disease deliver self help groups for others with similar conditions and other services e.g. Running the resource library – make sure it is up to date with the right kinds of resources available and create different window displays according to the public campaigns e.g. winter flu vaccination season, promotion of T2Diabetes prevention	
EMBED AND MONITOR THE SYSTEM	
Access and care redesign training is part of induction	
Roles and responsibilities are written in job descriptions and employment contracts for staff and patient volunteers	
Access and care redesign is a standing item in meetings	
Patients are seen as a key contributor to the success of any and all the initiatives in the practice	
Access and care redesign is acknowledged as the responsibility of the entire practice	
ESTABLISH A CONTINGENCY PLAN	
Written contingency plans cover predictable and unpredicted events e.g. Plans are in place for flu season and sudden GP illness	
Practice nurses see patients where appropriate	
Appointments added for limited time to meet additional demand	
Necessary consultations are prioritised e.g. Meetings and insurance medicals are postponed	
Policies are in place for taking annual leave	
Regular locums are employed well in advance	
Patients are advised of contingency plans on practice website	