Practice Management Toolkit

PRIMARY HEALTH NETWORK

phn
HUNTER NEW ENGLAND AND CENTRAL COAST
An Australian Government Initiative

CONTENTS

Hunter New England Central Coast Limited is a not for profit organisation funded primarily by the Federal government to operate a Primary Health Network (PHN). PHNs are responsible for improving the health of their communities by working cooperatively with hospitals (both public and private), general practitioners, specialists, nurses and midwives, and allied health professionals.
HNECC covers a diverse geographical area reaching from the Queensland border in the north to Gosford in the south, and west past Narrabri and Gunnedah.
HNECC respectfully acknowledges the traditional owners and custodians of the land in the region that it covers which include the traditional nations of the Awabakal, Biripi, Darkinjung, Geawegal, Kamiliroi, Wonnarua and Worimi people.

INTRODUCTION

Overview

Effective practice management leadership enables the delivery of cost effective, high quality healthcare, improved patient experience and clinician enrichment. This can be achieved by supplementing more conventional reactive approaches to care delivery with more pro-active and preventative models of care.

Practice managers are key agents of change who are uniquely positioned to lead practices as they pivot towards a more proactive approach to care provision. Fundamental to this shift of focus is the need to ensure practices are built on solid foundations of excellent customer service, positive company culture, strong marketing strategy, ability to adapt to change., data driven strategic decision making, operational and finance system management. By focusing on these fundamentals, practice managers can create an environment where both traditional and innovative approaches to care delivery can be achieved.

One of the challenges facing practice managers is the broad range of tasks they are responsible for. Tasks that practice managers undertake may be categorised into the following three key areas:

1. The practice team.
2. Finance and business.
3. The patient experience.

This toolkit has been designed to help practice managers identify opportunities for improvement across these areas and to successfully drive positive change within their practice.

At a glance

The Australian Institute of Health and Welfare have stated that, "Hospitalisation could have potentially been prevented through the provision of appropriate preventative health interventions and early disease management in primary care and community-based care settings (including by general practitioners, medical specialists, dentists, nurses and allied health professionals)".[i] [ii]

There were nearly 748,000 potentially preventable hospitalisations in Australia in 2017-18. Nearly 10% of all hospital bed days were for potentially preventable hospitalisations.

Practice Managers can use data extraction tools (E.g. PenCS's Clinical Audit Tool 4 (CAT4)) to identify patient groups for clinicians to review and consider for chronic disease management. It is widely accepted that well managed chronic disease patients are less likely to require hospitalisation .

Approaching quality improvement in your practice

1. Create a quality improvement (QI) strategic plan.
2. Using the Model for Improvement (MFI) format, complete Step 1.

E.g. Develop your QI goal, measures and brainstorm some ideas for implementation.

3. Using the Model for Improvement (MFI) format, complete Step 2.

E.g. Choose one idea from Step 1 of your MFI and implement a Plan, Do, Study, Act Cycle.

Please refer to the Continuous Quality Improvement Fundamentals Guide for General Practice for detailed information as to how to complete these three steps.

To support QI work within your practice, the PHN hosts a Primary Care Quality Improvement Community of Practice (QI CoP). The CoP is a place where primary care providers, practice teams and staff can float ideas, discuss best practice approaches, share resources and learn about successful quality activities that have been implemented. The Primary Care QI CoP site is available to primary care providers within the Hunter, New England & Central Coast regions. The PHN also hosts monthly quality improvement webinars on clinical areas of interest to provide additional support to QI CoP members. Please contact the PHN or your Primary Care Improvement Officer (PCIO) to learn how to gain access to this resource.

Cultural awareness, responsiveness and safety

Cultural awareness is sensitivity to the similarities and differences that exist between different cultures and the use of this sensitivity in effective communication with members of another cultural group.[iii]

Cultural awareness training is a formal information sharing process that fosters an understanding and appreciation of the differences between persons from other cultures, countries or backgrounds. This may include but is not limited to Aboriginal and Torres Strait Islander populations, Culturally and Linguistically Diverse (CALD) populations, refugees, and LGBTQIA populations. Cultural awareness training should be provided to all commencing staff and all existing staff at least every two years.

Cultural responsiveness refers to health services that are respectful of, and relevant to, the health beliefs, health practices, cultures and linguistic needs of Aboriginal and Torres Strait Islander populations. Cultural responsiveness describes the capacity of the health system and individual providers to respond to the health needs of Aboriginal and Torres Strait Islander communities. It is a cyclical and ongoing process, requiring regular self-reflection and proactive responses to the person, family or community interacted with. It requires knowledge and capacity at different levels of intervention: systemic, organisational, professional and individual.

Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities. Culturally safe practice is only possible when individuals and organisations participate in the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practicing behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism. To ensure culturally safe and respectful practice, health practitioners must:

- Acknowledge colonisation and systemic racism, social, cultural, behavioural and economic factors which impact individual and community health;
- Acknowledge and address individual racism, their own biases, assumptions, stereotypes and prejudices and provide care that is holistic, free of bias and racism;
- Recognise the importance of self-determined decision-making, partnership and collaboration in healthcare which is driven by the individual, family and community;
- Foster a safe working environment through leadership to support the rights and dignity of Aboriginal and Torres Strait Islander people and colleagues.[iv]

READINESS CHECKLIST

Is your practice ready to make changes?

There are many ways to improve practice management. This readiness checklist is designed as a starting point to encourage general practice to generate ideas and strategies in practice management that may be applied to a quality improvement activity. This checklist is also designed to assist practice managers in identifying opportunities, and guide innovations for a practice that is thriving in the future.

Completing this checklist will assist with the 'thinking part' (Step 1) of the quality improvement cycle (see the template at the end of this toolkit).

In working through the readiness checklist, start by identifying if the practice is undertaking activity in the identified area. In the action column you could document any ideas or processes that may need to be introduced or changed.

Practice Management Quality Improvement Readiness Checklist

General Practice Name:	
Completed by:	
Trained Health Practitioner:	

AREA: Quality improvement change readiness	Yes/No	Action/Comment (what, when, who)
1. There is active and engaged leadership focused on improving the business model for sustainability and business growth.		
2. There is active and engaged leadership focused on improving the patient experience and improving health outcomes for patients.		
3. The practice uses the Model for Improvement (including the Plan, Do, Study, Act cycle) to support quality improvement activities and to drive change in patient care.		
4. The practice manager can demonstrate to the team how to use data for quality improvement and encourages them to do the same.		
5. The practice is goal focused and consults with team members when reviewing processes.		
6. The practice celebrates goal achievements with all team members and team member efforts are acknowledged.		
7. The practice uses CAT4 and other processes to identify business opportunities for future growth and better service delivery for patients.		

8. The clinical team ensures that patient records are correctly coded for accurate data collection and mapping. This enables practice participation in the Practice Incentive Payment Quality Improvement (PIP QI).		
9. Cleansing CAT (part of PenCS' CAT4 suite of tools) are regularly used by the practice to ensure data is up to date and to support continuous quality improvement.		
10. There is a recall and reminder policy that is discussed regularly at all team member meetings.		
11. The practice has established ongoing relationships with other relevant organisations including community organisations, pharmacy, allied health, Aboriginal and Torres Strait Islander health organisations, and business community organisations as appropriate (E.g. mines).		
AREA: Information systems and data driven improvement	**Yes/No**	**Action/Comment (what, when, who)**
12. The practice manager's role is focused on efficient & effective work practices, staff satisfaction, patient satisfaction, patient satisfaction and their health outcomes.		
13. The practice manager has the skills and tools needed to plan, monitor and improve practice's model for income generation to ensure business viability. Note: Tools to support this are available from the PHN, contact your PCIO.		
14. All staff understand they work in a business and that their work contributes to the income generation of the practice.		
15. The practice manager uses CAT4 and other supplied software reports to review and track MBS billings, to identify missed opportunities & deal with rejected payments.		
16. There is a policy in place to ensure all GP's are responsible for correcting any errors and changes with MBS billings.		
17. The general practice's appointment book is set up by workday to show appointment types and times for all clinical staff to allocate the time needed for patient care. Template available from the PHN, contact your PCIO.		
18. The practice has a regular review schedule of practice systems and processes in place. E.g. HR, IT, workflow systems, recalls and reminders, team members meetings, clinical meetings, accreditation, practice resource management, managing appointments, financial management.		
19. The practice regularly updates their software to ensure patient care is optimal (including CAT4, Scheduler, TopBar, PRODA/HPOS, AIR, SeNT eReferral, ePrescribing, Capacity Tracker etc.).		
20. The practice regularly audits their software and equipment to ascertain the need for new items and/or maintenance of current resources.		
21. The practice regularly provides professional development opportunities for all staff to learn about new software approaches and installations.		

AREA: General Practice Systems	Yes/No	Action/Comment (what, when, who)
22. Relevant staff use CAT4 to generate patient reports and/ or lists for targeted work (E.g. A nurse could create a list of diabetic patients who have not had a HbA1c in the last 12 months, or patients with a cardiovascular disease without a blood pressure measure in the last 6 months. These examples are relevant to the PIP QI).		
23. Reports generated from CAT4 are shared with GP's regularly to determine if their patients would benefit from chronic disease management of their condition. Note: this task could be completed through a monthly clinical meeting.		
24. An all staff meeting is held regularly (at least monthly) and includes standing agenda items E.g. Patient Management and current QI Activity success/choice etc		
25. All consults for nurses & GP's are scheduled in the practices appointment book with time allocated to reflect the care given to patients by the whole clinical team		
26. All relevant clinical staff are allocated dedicated time for: a. cold chain management b. ordering and/or managing stores c. assist the GP with procedures where appropriate d. immunisation clinics e. accreditation preparation f. follow up with patients.		
27. Nurse contribution to chronic disease management is reviewed on a weekly basis by the practice manager to ensure the nurse/s are being used for best patient care. Template available from the PHN, contact your PCIO.		
28. All GP's, nurses and administration team members are aware of the changes legislated in the 2017/2018 Federal Budget for Improved Medicare Compliance for: a. Debt Recovery, effective 1st July 2018. b. Shared Debt Recovery Scheme (SDRS), effective 1st July 2019. Click here for Compliance Changes to Legislation.		
29. General practice management assesses staffing & roster to ensure the right allocation of the right staff at the right time to meet patient and business requirements.		
30. The practice has a policy to review the performance and remuneration of all team members annually. The practice manager implements and documents the outcomes of these reviews.		
31. Software tools such as SMS are used to maximise appointment attendance, keep patients on time and reduce the risk of patients not attending.		
32. Privacy requirements for SMS messaging to patients are in place as per current legislation. These are documented in the practice's Patient Information Sheet.[v] [vi]		

33. All patients are scheduled for their next chronic disease management appointment before they leave their current chronic disease management (CDM) appointment. E.g. appointments booked three months in advance. Any leave for clinicians is requested and approved 3 months in advance to allow the right team to be in place when booking CDM appointments.		
34. All staff have defined roles and position descriptions; these are reviewed with them regularly. E.g. Practice managers have capacity to complete all elements of their position description.		
35. All staff are encouraged to participate in further training and education opportunities for personal growth and job satisfaction.		
36. Professional development opportunities are identified and protected time for development is given to all staff.		
37. The practice promotes a good work culture, manages conflict constructively, encourages innovation and job satisfaction		
38. The practice management team understand and can apply change management principles in the practice.		
39. The practice has an internal communication policy including expectations of staff around use of social media, online forums, individual community engagement etc.		
40. The Practice regularly provides updates for stakeholders when there changes that impact how they conduct business with the practice. E.g Introducing a new GP to the practice or change in opening times etc		
41. The practice has appropriate induction processes and ongoing training in place to support reception and administration staff in the delivery of their role. E.g. correspondence received by the practice being directed and actioned appropriately, managing phone calls appropriately in to and out of the practice.		
AREA: Person centred care	**Yes/No**	**Action/Comment (what, when, who)**
42. The practice's leadership team demonstrates and champions a focus on comprehensive patient care.		
43. Supported patient care is underpinned by practice policies that direct communication with other health care providers, forming the foundation of all Team Care Arrangements (TCA's 723) to ensure comprehensive care co-ordination and correct billing compliance.		

44. The practice uses CAT4 to identify patients eligible for General Practitioner Management Plans (GPMP) and/or Team Care Arrangements (TCA) creation and reviews of current plans.		
45. The practice has a process in place to contact patients prior to a scheduled chronic disease appointment and ensure patients attendance or reschedule if needed.		
46. The practice has a process in place along with protected time for relevant staff to recall patients, develop reports, and other administration associated with chronic disease management and care.		
47. The practice provides updates to the practice population via a patient information sheet available in the waiting room & updates via their webpage.		
48. The practice prioritises providing all patients with the GP of their choice to provide consistent patient care.		
49. The practice has in place processes to encourage patients to develop an understanding of their own health E.g. the patient's role and responsibility in improving and maintaining their own health (this outcome can be supported through 10997's or 10998's).		
50. The practice understands and regularly reviews their patient population demographics and subsequently tailors their care to the population. E.g. high numbers of aged population would necessitate nurse training in 75+ year health assessments and allied health services for podiatry.		
51. The practice team works to prevent the development of chronic disease for their practice population by using Health Assessment models of care and have recalls in place to ensure this care is completed		
52. All team members have a 'whole of practice' approach to caring for patients with a chronic disease and understand the role of other team members in contributing to the patient journey.		
53. The practice considers patient satisfaction through: • having consistently planned appointments, addressing waiting times. • making sure there are right staff are available at the right times for patients. • having well educated staff who have opportunities to upskill including quarantining time and supporting education. • engaging stakeholders including being present within the community. • nurturing collaboration within the team. • encouraging and valuing contributions and ideas for all staff. • actively working towards a positive workplace. • providing continuity of care to all patients.		

CHANGE IDEAS TO CONSIDER

These ideas are suggestions only, with the concept adaptable across the practice's approach to practice management.

Idea: Schedule monthly clinical and whole of practice meetings to improve communication amongst all members of the team. These meetings can provide:

- An opportunity to introduce and use a Model for Improvement including a Plan, Do, Study, Act (PDSA) cycle and reviews of PDSA cycles.
- A forum for enabling all team members to engage in the development and implementation.
- Quality improvement initiatives

Idea: Engage the General Practice Team to develop and maintain an effective recall and reminder system.

- Ensure your practice has a documented policy regarding the management of recalls and reminders.
- Review the recall and reminders policy at team meetings to ensure team members understand the system.
- Having an effective recall and reminder system in place may also improve patient outcomes, practice business sustainability and income generation.

Idea: Appoint and train a team member who has the primary responsibility for leading quality improvement systems and processes. Document the responsibilities of this role in the position description. The identified team member:

- Can become the practice champion for quality improvement and be given professional development opportunities to expand their skill set.
- Leads the team involved in the quality improvement activity/ies to ensure a single point of contact.
- Assists in leading/driving the development of the QI Strategic Plan for the practice.
- Rotates around the practice to build skills and capability in quality improvement processes and delivery amongst different members of the team

Idea: Draft and implement a written procedure for a patient feedback.

- Develop a practice policy for patient feedback including analysis of the feedback received; use this feedback to improve the quality of the practice's care.
- Consider what patient feedback aligns with the practice's strategic objectives. Include consideration of this as a standing agenda item in team meetings.

Idea: Ensure patient waiting time is used to engage them in developing their understanding of their own health journey by using patient self-assessment tools while they are waiting.

- Examples of patients self-assessment tools are as follows (but not limited to): Ausdrisk Tool, Sleep Study, Family History Template (available from the RACGP website) or a weekly exercise survey.
- The results of patient self-assessment tools can be reviewed with a clinician during the patient appointment and can help to inform the accuracy of the patient file.
- This is an opportunity to address preventative health measures to improve patient outcomes.

Idea: Document the established and ongoing external partnerships and relationships the practice has to support patient care.

- Develop a register with contact details of all external partners.
- Send a notification out to all partners and external stakeholders when a new GP or allied health provider joins the practice team.
- If the practice starts offering allied health support, all partners and external stakeholders are notified.
- Maintaining a register assists with internal staff handover.

CHANGE IDEAS TO CONSIDER CONTINUED...

Idea: Regularly reviewing practice systems and processes

- Consider inclusion and review of: HR, IT, Workflow systems, Recalls and Reminders, Team members Meetings, Clinical Meetings, Accreditation, Practice Resource Management, Managing Appointments, Financial Management.

Idea: Professional development opportunities are provided to staff.

Examples of professional development opportunities include:

- Health assessment training and competency updates;
- Patient Journey Training provided by the PHN and other entities;
- Planned Patient Care and Income Generation Model in General Practice Training provided by the PHN;
- Online Compliance Education for Health Professionals training from the Department of Health.

UNDERTAKING QI
USING THE MODEL FOR IMPROVEMENT

Quality Improvement Goal Setting

STEP 1: Ask the three questions.

1. What are we trying to accomplish?
By answering this question, you will develop your goal for improvement.

2. How will we know that a change is an improvement?
By answering this question, you will develop measures to track the achievement of your goal.

3. What changes can we make that can lead to an improvement?
List your ideas for change.
By answering this question, you will develop the ideas you would like to test towards achieving your goal. Use the SMART approach when developing ideas (specific, measurable, attainable, realistic, timebound). E.g. By March 2020, complete 100% of HbA1c tests for all eligible (have not had a test in the past 6 months) active patients.

IDEA 1.

IDEA 2.

IDEA 3.

IDEA 4.

QI Implementation: Plan, Do, Study Act Cycle

STEP 2: Choose one idea from Step 1 and expand into a PSDA Cycle.

Idea being tested: From Step 1: Idea 1, 2, 3 or 4	
	**Plan** Who? When? Where? Data predictions? Data to be collected.
	**Do** Was the plan executed? Any unexpected events or problems? Record data.
	**Study** Analysis of actions and data. Reflection on the results. Compare to predictions
	**Act** What will we take forward; what is the next step or cycle?

Resources

- RACGP Standards 5th Edition. 2020. Retrieved from Royal Australian College of General Practitioners: https://www.racgp.org.au/running-a-practice/practice-standards/standards-5th-edition
- Potentially preventable hospitalisations in Australia by age groups and small geographic areas. 2017-2018. Retrieved from Australian Institute of Health and Welfare: https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/contents/overview
- The 10 Building Blocks of High-Performing Primary Care. 2014. Retrieved from Annals of Family Medicine: http://www.annfammed.org/content/12/2/166.long

The following tools and resources are available through your Primary Care Improvement Officer (PCIO):

Practice Manager Financial Tools –

- Nurse Contribution Report
- GP Income Generated & Payment Report
- Practice Weekly Budget Planner

Other Management Tools

- Appointment Types & Times Template
- Next Consult Slip

Practice education available from your PCIO:

- Journey of a Chronic Disease Patient through the practice over 12 months
- A Planned Patient Care & Income Generation Model in General Practice
- Health Assessment Workflow – Where are our Opportunities

Relevant Health Pathways

- Practice Incentives Program

References

i Potentially preventable hospitalisations in Australia by age groups and small geographic areas. 2017-2018. Retrieved from Australian Institute of Health and Welfare: https://www.aihw.gov.au/reports/primary-health-care/potentially-preventable-hospitalisations/contents/overview

ii A guide to the potentially preventable hospitalisations indicator in Australia. 2017. Retrieved from Australian Commission on Safety and Quality in Health Care: https://www.safetyandquality.gov.au/sites/default/files/migrated/A-guide-to-the-potentially-preventable-hospitalisations-indicator-in-Australia.pdf

iii Cultural Awareness. 2020. Retrieved from Health Education & Training Institute: https://www.heti.nsw.gov.au/education-and-training/courses-and-programs/international-medical-graduate-information/cultural-awareness

iv The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025. Retreived from AHPRA & National Boards: https://www.ahpra.gov.au/About-AHPRA/Aboriginal-and-Torres-Strait-Islander-Health-Strategy.aspx

v SPAM Act 2003. Retrieved from Australian Government Federal Register of Legislation: https://www.legislation.gov.au/Details/C2014C00214

vi Recommendations when using SMS messgaing. 2016. Retrieved from Avant Mutual: https://www.avant.org.au/Resources/Public/20160113-factsheet-recommendations-when-using-sms-messaging/

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