



RACGP

Royal Australian College of General Practitioners

Standards for Patient-Centred Medical Homes

**Patient-centred, comprehensive, coordinated,
accessible and quality care**



Standards for Patient-Centred Medical Homes: Patient-centred, comprehensive, coordinated, accessible and quality care

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We recognise the traditional custodians of the land and sea on which we work and live.

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Introduction

The RACGP *Standards for Patient-Centred Medical Homes* (Medical Home Standards) have been produced for piloting purposes.

The Medical Home model

The Medical Home Standards align with the five elements of the medical home, which are:

1. Comprehensive care
2. Patient-centred care
3. Coordinated care
4. Accessible services
5. Quality and safety.

The Patient-Centred Medical Home (Medical Home) facilitates a partnership between individual patients, their usual treating general practitioner (GP), and extended healthcare team, which enables better-targeted and effective coordination of clinical resources to meet patients' needs. It also provides the GP or practice with clarity, through information sharing and collaboration, regarding the patient's treatment, testing, and diagnosis outside of the general practice, including adverse events and hospitalisations.

The RACGP defines the Medical Home as a GP-led concept that extends the workings of a general practice. The RACGP envisions that the Medical Home will be housed within a general practice or Aboriginal Medical Service with links to other practitioners or services involved in the delivery of care to the patient. Patient care and coordination between the practice and other healthcare providers will be facilitated by a person in a specific coordinator role.

There is no single model of healthcare for the Medical Home. Overseas medical home models differ almost as much as they share similarities. However, the key features of the Medical Home are as follows.¹

- Patients voluntarily enrol with a practice or healthcare provider to provide a clinical 'home-base' for the coordination, management and ongoing support of their care.
- Patients, their families and carers are partners in patient care where patients are empowered to increase their knowledge, skills and confidence to manage their health, helped by technology and the support of a healthcare team.
- Patients have better access to care provided by the practice, which may include support by telephone, email or videoconferencing, and access to after-hours advice or care.
- Patients nominate a preferred practitioner who is aware of their problems, priorities and wishes, and is responsible for their care coordination.
- There is flexible service delivery and team-based care that supports integrated patient care throughout the health system, through the sharing of information and the planning of care.
- There is commitment to high quality and safe care. Planning of care and clinical decisions are guided by evidence-based patient healthcare pathways, appropriate to the patient's needs.
- Data is collected and shared by patients and their healthcare teams to measure patients' health outcomes and improve performance.

The RACGP's Medical Home Standards

The RACGP's Medical Home Standards cover all aspects of the Medical Home model. By definition, this model is broader than the Federal Government's Health Care Homes model as it covers care for all patients in the practice, not only those with complex conditions. The Medical Home Standards may therefore contain more information than Health Care Homes require. Regardless, the Medical Home Standards are applicable to both Medical Homes and Health Care Homes.

The RACGP's Medical Home Standards build on the areas in the RACGP's *Vision for general practice and a sustainable healthcare* system ('the Vision'). They are:

1. Medical Home governance
2. Patient-centred care
3. Coordinated care
4. Comprehensive preventive, acute and chronic disease care
5. Accessible care
6. Safe, high quality care.

The Health Care Home

The Federal Government defines the Health Care Home as an approach where patients living with multiple complex and chronic illnesses enrol with their GP to have their conditions and healthcare needs managed. The Health Care Home is considered a component of the Medical Home.

Relationship to the RACGP's Standards for general practices

There is significant overlap between the requirements of a medical home and requirements of general practice, as set out in the RACGP's *Standards for general practices* (the Standards) – both current (4th edition) and future (5th edition). However, there are also differences in the content and emphases that extend beyond the requirements of a general practice. Due to these differences, it would not be appropriate for the RACGP to simply state that general practice accreditation is sufficient for medical homes.

Given that the Health Care Home pilot and other pilots will occur before the 5th edition Standards are released, the Medical Home Standards will initially be a stand-alone document. For this reason, there is some duplication between the Medical Home Standards and the 5th edition Standards. After the 5th edition Standards are released in October 2017, the RACGP plans to add the Medical Home Standards as a module of the Standards.

Use of the Medical Home Standards

These Standards have been developed for piloting the Medical Home and Health Care Home models. The RACGP is seeking feedback throughout the implementation of the pilots, including but not limited to, applicability of the drafted Standards, usability, and feasibility.

Structure of the Medical Home Standards

Consistent with the development of the draft 5th edition Standards, the Indicators in the Medical Home Standards have been drafted with an outcome-focus, where possible. The Indicators that are flagged as mandatory in the Medical Home Standards are also flagged as mandatory in the draft 5th edition Standards, or are considered critical to the Medical Home and Health Care Home models.

Although the USA's medical home standards are prescriptive in nature, the RACGP's Medical Home Standards have been developed as a guide to help practices successfully meet the requirements of a Medical Home, maintain high quality and safe patient-centred care, and avoid unnecessary burden.

The RACGP expects that the Medical Home will be GP-led and based within a general practice or Aboriginal Medical Service. For this reason, the terminology used in the Medical Home Standards refers to requirements of the practice where the Medical Home is based.

Mandatory ► and aspirational Indicators

Indicators marked with this symbol ► are mandatory, which means that your practice must demonstrate that you meet this Indicator in order to achieve accreditation against the Medical Home Standards.

Indicators that are not marked with the mandatory symbol are aspirational Indicators. We encourage all practices to meet the aspirational Indicators, but it is not essential to achieve accreditation.

Standard 1. Practice governance

Integrated governance and management systems can help you maintain and improve the quality of care provided to patients.

Criterion 1.1 – Practice governance

Indicators

- ▶ **A.** Our practice uses a shared electronic patient record system for all enrolled patients that can be accessed by all members of the care team.
- ▶ **B.** Our practice has agreements in place with other health professionals/services who are part of the care team and external to the practice.
- ▶ **C.** Our practice has agreements in place with patients who are enrolled.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>It is essential that the practice uses a shared electronic patient record system to share health summaries and event summaries between members of the care team.</p> <p>The practice can choose to use one of the systems listed below or another system that meets the requirements of this Indicator:</p> <ul style="list-style-type: none"> • My Health record • CDMnet <p>To ensure that all members of the care team have access to shared records, all members of the care team must use either the same system or systems that integrate.</p> <p>The RACGP's Digital business kit provides a suite of resources and general guidance to promote the adoption and meaningful use of technologies in the practice. Kit 1.5 covers the National eHealth Record System and includes information regarding health summaries. This information is available at www.racgp.org.au/digital-business-kit/national-ehealth-records-system</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.</p> <p>Items in red are mandatory.</p> <p>Items in black are optional.</p> <ul style="list-style-type: none"> • Use a shared electronic patient record system that can be accessed and updated by all members of the care team. • Have a policy on what information needs to be included in health summaries and event summaries.

<p>► B</p>	<p>Explanation</p> <p>To provide effective self-management support, the care team and administrative staff need to coordinate closely with each other to provide care before, during, and after the patient's visit.</p> <p>Written agreements between the practice and members of the care team operating outside the practice support continuity of care and the timely handover of clinical patient information to the patient's preferred practitioner.</p> <p>It is therefore important that agreements be in place between the practice and members of the entire care team.</p> <p>Practices should also consider whether they need agreements with local hospitals.</p> <p>These agreements should articulate the roles and responsibilities, communication, areas and levels of accountability, and decision-making processes.</p> <p>Written agreements could include that:</p> <ul style="list-style-type: none"> • the care team member will: <ul style="list-style-type: none"> – discuss and review shared team care plans with the patient's preferred practitioner – discuss health and treatment goals with the patient and their preferred practitioner – treat the patient/carer with respect – provide the patient/carer with adequate information regarding their diagnosis and treatment options – empower the patient/carer to be involved in decisions involving their healthcare – meet the cultural and linguistic needs of the patient/carer – make appointments available to the patient within the timelines requested by the patient's preferred practitioner – send an event summary detailing the clinical management of the patient to the patient's regular practitioner the next business day (with the patient's consent and preferably via secure message delivery) – send any findings following a referral to the patient's regular practitioner the next business day – communicate to the practice if the patient is unable to attend an appointment. • the practice will: <ul style="list-style-type: none"> – provide an accurate and up-to-date health summary to members of the care team – provide accurate and up-to-date event summaries to members of the care team – provide a sufficient explanation of why a referral or test has been ordered – communicate with members of the care team when a referral has been issued to the patient.
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.</p> <p>Items in red are mandatory.</p> <p>Items in black are optional.</p> <ul style="list-style-type: none"> • Have written agreements between the practice and members of the care team providing care outside the practice. • Have written agreements between the practice and local hospitals.

<p>► C</p>	<p>Explanation</p> <p>Written arrangements between the practice and enrolled patients support patient empowerment and can foster shared decision-making.</p> <p>These agreements need to clearly state the:</p> <ul style="list-style-type: none"> • members of the care team • role of the care team and the patient • rights, responsibilities and obligations of the care team and the patient • levels of accountability • name and role of a patient's carer or family, if relevant • decision-making processes. <p>The agreements could also include specific requirements for the patient, such as:</p> <ul style="list-style-type: none"> • access • safety • respect • communication • participation • privacy • feedback processes. <p>The Australian Commission on Safety and Quality in Health Care (ACSQHC) has a Charter of Healthcare Rights that aims to facilitate a common understanding of the rights of people receiving healthcare. It is available at www.safetyandquality.gov.au/national-priorities/charter-of-healthcare-rights</p> <p>The RACGP's Patient Charter (available for members at www.racgp.org.au/gppatientcharter) aligns with the ACSQHC's Charter of Healthcare Rights, and describes the responsibilities of patients.</p> <p>Individual states and territories may also have patient charters for Aboriginal and Torres Strait Islander peoples unique to that state or territory.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Have a written agreement with patients enrolled in the practice. • In the patient's record, document discussions regarding the patient's roles and responsibilities.

Criterion 1.2 – The care team

Indicators

- ▶ **A.** Our practice works with a multidisciplinary care team comprised of healthcare providers from within and outside the practice to provide a range of services.
- ▶ **B.** There is a member of the practice team responsible for coordinating patient care across the care team.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>In order to meet this Indicator, the care team structure (including the roles of clinical and administrative team members) needs to be defined. It is important that this information is documented and available to all members of the care team.</p> <p>The practice should consider the healthcare needs of patients, including consideration of local/regional population data, when determining who to include in the multidisciplinary care team and what services to provide.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Document the responsibilities of care team members in agreements. • Create service provision descriptions for all members of the care team. • Create an organisational chart. • Maintain a policy containing this information. • Collaborate with Primary Health Networks (PHN)s to understand the needs of the population.
▶ B	<p>Explanation</p> <p>A care coordinator can facilitate the healthcare of patients across multiple settings and communicate with patients/ carers and the care team within and outside of the practice.</p> <p>It is critical that this person is known to all members of the care team and that their responsibilities are documented and accessible to all members of the care team.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Have a care coordinator who is known to all members of the care team. • Provide documentation to all patients and members of the care team that includes the name and role of the coordinator.

Criterion 1.3 – Qualifications and training

Indicators

- ▶ **A.** Members of our care team:
 - have current national registration where applicable
 - have accreditation/certification with their relevant professional association
 - actively participate in continuing professional development (CPD) relevant to their position and in accordance with their legal and/or professional organisation's requirements.
- ▶ **B.** Administrative staff undertake training appropriate to their role and the practice's patient population.
- C.** Our clinical team considers ethical dilemmas.
- D.** Our practice has an open disclosure process based on the *Australian Open Disclosure Framework*.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>Using suitably qualified and trained healthcare practitioners reduces the risk of medical errors and provides patients with safe, high-quality care.</p> <p>All healthcare practitioners:</p> <ul style="list-style-type: none"> • must be suitably accredited, qualified and trained • must maintain the necessary knowledge and skills that enable them to provide good clinical care • are expected to comply with the professional development requirements of the relevant professional organisation, whether or not they are a member of the organisation • are expected to comply with the code of conduct of the relevant professional organisation, whether or not they are a member of the organisation • must work within their scope of practice and competencies • are expected to undertake Aboriginal and Torres Strait Islander cultural awareness training where relevant.
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.</p> <p>Items in red are mandatory.</p> <p>Items in black are optional.</p> <ul style="list-style-type: none"> • Keep current practitioner registration records. • Keep CPD records. • Keep training logs that record training that practitioners have completed. • Record staff qualifications in agreements. • Keep a training and development calendar. • Conduct annual performance reviews that identify learning and development goals. • Store documents that identify staff training needs and completed training. • Specify required staff qualifications in job descriptions.

<p>► B</p>	<p>Explanation</p> <p>Administrative staff require training appropriate to their role and the practice's patient population. This may include formal courses in areas such as:</p> <ul style="list-style-type: none"> • practice procedures • use of technology (hardware, systems, and software) • first aid • medical terminology • reception duties • Aboriginal and Torres Strait Islander health • Aboriginal and Torres Strait Islander cultural awareness • cross-cultural safety training • safe operation of practice equipment. <p>Practitioners or other staff can deliver in-house or 'on-the-job' training in practice-specific areas, such as:</p> <ul style="list-style-type: none"> • using the patient records system • making appointments • recognising medical emergencies when patients present in reception • confidentiality requirements • the practice's policies and procedures.
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Record staff qualifications in employee files. • Keep training logs that record the training that administrative staff have completed. • Specify required staff qualifications in job descriptions. • Keep a training and development calendar. • Conduct annual performance reviews that identify learning and development goals, training needs, and training completed. • Store documents that identify staff training needs and completed training.
<p>C</p>	<p>Explanation</p> <p>Practitioners often need to manage ethical issues in primary healthcare in many different situations that range from bioethical dilemmas (including end-of-life care and pregnancy termination) to receiving gifts from patients.</p> <p>In particular, ethical dilemmas may arise when considering:</p> <ul style="list-style-type: none"> • decisions not to treat • decisions to withdraw or discontinue treatment • decisions not to provide treatment as per the patient's wishes. <p>Practices should have a process to appropriately navigate ethical dilemmas in a timely way.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Develop a policy or procedure on how the clinical team considers ethical dilemmas. • Document in the patient record any ethical dilemmas that have been considered and how they have been managed. • Provide evidence that practitioners adhere to their own professional obligations and code of ethics. • Discuss ethical dilemmas at clinical team meetings. • Provide a buddy or mentoring system that gives staff opportunities to discuss ethical dilemmas. • Use a clinical intranet or group email to pose common ethical dilemmas for clinical staff to consider and discuss possible solutions. • Implement quality improvement initiatives, such as a brochure for patients, to give patients more information about a particular issue.

<p>D</p>	<p>Open disclosure is defined as:</p> <p><i>'An open discussion with a patient about one or more incidents that resulted in harm to the patient while they were receiving healthcare.'</i></p> <p>Health professionals have an obligation to:</p> <ul style="list-style-type: none"> • respectfully explain to patients when things go wrong • offer an expression of regret or genuine apology (if warranted) • explain what steps have been taken to ensure that the mistake is not repeated. <p>The RACGP has endorsed the <i>Australian Open Disclosure Framework</i> developed by the ACSQHC, available at www.safetyandquality.gov.au/our-work/open-disclosure/the-open-disclosure-framework</p> <p>The <i>Open Disclosure Framework</i> for small practices is available at www.safetyandquality.gov.au/publications/implementing-the-australian-open-disclosure-framework-in-small-practices</p> <p>Communicating openly and honestly is important so that the patient can:</p> <ul style="list-style-type: none"> • move on • have better relationships with practitioners • be more involved in their care. <p>In addition, if the patient receives a genuine explanation and apology, they are less likely to pursue litigation.</p> <p>Open disclosure includes:</p> <ul style="list-style-type: none"> • an apology or expression of regret (including the word 'sorry') • a factual explanation of what happened • an opportunity for the patient to relate their experience • an explanation of the steps the practice or practitioner is taking to manage the event and prevent recurrence. <p>Open disclosure is a discussion and an exchange of information that may take place over several meetings. It is important that staff listen to what the patient says in response to the open disclosure made and demonstrate that they have learnt from the incident. If no actual harm resulted, the practice could record the incident as a 'near miss' in their risk register.</p> <p>There is a potential for errors to be made when you are communicating with people outside the practice. Open disclosure refers to both communication with patients about an error and communication with all other members of the care team.</p> <p>It is important to contact your medical defence organisation for further guidance and advice about when you may need to participate in open disclosure.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.</p> <p>Items in red are mandatory.</p> <p>Items in black are optional.</p> <ul style="list-style-type: none"> • Maintain an open disclosure process. • Keep a record of any discussions and apologies in a file separate to patient records. • Provide a verbal account of the open disclosure process staff undertook in response to an incident. • Record any open disclosure incidents in the near miss and risk register. • Discuss open disclosure during induction.

Standard 2: Patient-centred care

Patient-centred care that prioritises the development of relationships between patients and providers.

Criterion 2.1 – Patients’ rights and empowerment

Indicators

- A. Our patients are partners in their care.
- ▶ B. Our patients are provided with privacy.
- ▶ C. Our patient information and health records are treated confidentially.
- D. Our practice assesses and builds the health literacy of our patients.
- ▶ E. Our patients receive information to support the diagnosis, treatment, and management of conditions.

Meeting this Criterion

A	<p>Explanation</p> <p>The ideal patient–practitioner partnership is a collaboration based on mutual respect and mutual responsibility for the health of the patient.</p> <p>The practitioner’s duty of care is to explain the benefits and potential harm of specific medical treatments and to clearly explain the consequences of the patient not following a recommended management plan.</p> <p>Practitioners have a responsibility to ensure that, when taking a history from a patient and developing management plans, the patient fully understands the discussion that takes place, and the proposed management and treatment. Using consistent terminology that the patient can understand will help achieve this.</p> <p>If a carer has an ongoing role in the patient’s day-to-day care, it is generally advisable to include the carer in the patient–practitioner relationship with the permission of the patient (if the patient is able to give such consent).</p> <p>Patients will feel respected if the reception staff are also positive, friendly, attentive, and empathetic.</p> <p>Patients have the right to refuse a recommended treatment, advice, or procedure and to seek other clinical opinions from other healthcare providers.</p> <p>Patients have a corresponding responsibility to be respectful and considerate towards the practitioners and other staff.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Include patients’ rights and responsibilities in agreements between the patient and the practice. • Have a documented complaints process. • Show that conversations noted in the patient record reflect respect, consideration, and dignity. • Maintain a patients’ rights policy. • Maintain a cultural safety policy for staff and patients so that your practice team knows they are required to provide care that is respectful of a person’s culture and beliefs, and free of discrimination. • Maintain an anti-discrimination policy.

► B	<p>Explanation</p> <p>Visual privacy includes physical privacy for patients and the privacy of patient health information. Visual privacy can be given to patients during the clinical examination by using a gown or sheet and an adequate curtain or screen. Members of the clinical team need to be sensitive to patient dignity when patients are required to undress/dress in the presence of the GP or nurse.</p> <p>Auditory privacy means a patient's conversation with a member of the clinical team cannot be overheard by an inappropriate person, such as another patient or staff member. No-one should be able to overhear consultations. Auditory privacy can be improved by playing appropriate background music to mask conversations between staff members and between staff and patients. In areas of the practice where auditory privacy is not possible, patients should be offered a private room.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none">• Ensure all consultation spaces have auditory and visual privacy.• Ensure secure access to patient health information.• Provide a room where distressed patients have privacy.• Develop a process outlining how the care team can provide patients with the utmost privacy in all interactions with the practice, from reception to consultations.
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► C

Explanation

Privacy of health information is a legislative requirement under the *Privacy Act 1988*.

Personal health information needs to be safeguarded to maintain confidentiality and privacy in accordance with the Australian Privacy Principles.

All healthcare providers are subject to stringent privacy obligations because they provide health services and hold health information. Health information is a subset of personal information and can include any information collected in order to provide a health service, such as:

- a person's name and address
- a person's bank account details
- a person's Medicare number
- health information (such as a medical or personal opinion) about a person's health, disability, or health status.

Details about a person's medical history or other information (such as details of an appointment) can sometimes identify the person, even if there is no name attached to that information. These details are considered health information and therefore must be protected in accordance with the *Privacy Act 1988*.

The practice needs to document a privacy policy to manage health information, and must inform patients of the policy. Privacy policies need to be written in plain English, specify a review date, and meet certain legislative requirements, including:

- obtaining informed patient consent when transferring health information
- the definition of a patient record
- how the practice collects, uses, and discloses personal information
- how patients can access and correct their health information
- why the practice collects personal information
- an explanation of the shared health summary
- how patients can complain about breaches of privacy, and how the complaint will be handled
- whether health information is likely to be disclosed overseas and, if so, where
- how the practice discloses patient record information, or provides access to people or organisations
- how automation technologies are used, particularly to ensure that only the relevant medical information is included in automatically generated referral letters
- processes regarding direct marketing
- processes for providing the privacy policy to patients when requested
- processes for keeping a record of a patient's informed consent in their medical record.

A statement relating to the adherence to the Australian Privacy Principles should also be included in agreements between the practice and any care team members.

Demonstrating how you meet this Indicator

The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.

Items in **red** are mandatory.

Items in **black** are optional.

- **Maintain a privacy policy.**
- **Show that administrative staff and the care team can produce the privacy policy when requested.**
- **Comply with the Australian Privacy Principles.**
- **Keep a record of the patient's informed consent in the patient record.**
- Include the need to adhere to the Australian Privacy Principles in agreements between the practice and members of the care team.

D	<p>Explanation</p> <p>Individual health literacy is defined as 'the skills, knowledge, motivation and capacity of a person to access, understand, appraise and apply information to make effective decisions about health and healthcare and take appropriate action'.²</p> <p>Having patients who are partners in the processes of health and healthcare is necessary to provide safe and high-quality care. Health literacy plays an important role in enabling effective partnerships between healthcare providers and patients. For partnerships to work, everyone involved needs to be able to give, receive, interpret, and act on information, such as treatment options and plans.</p> <p>Assessing the health literacy of patients and providing them with information based on that assessment helps to make patients fully aware of and understand their diagnosis, condition, treatment options and the possible risks or side effects of medications or treatments.</p> <p>Practitioners can build a patient's health literacy by:</p> <ul style="list-style-type: none"> • recognising the patient's needs and preferences and tailoring communication accordingly • assuming that most people will have difficulty understanding and applying complex health information and concepts • providing health information in an unrushed manner using words that the patient understands • using multiple communication strategies to confirm that information has been delivered and received effectively • providing access to targeted information such as leaflets, websites and online support groups • encouraging the patient, carer and other relevant parties to speak up if they have difficulty understanding the information provided • using proven methods of communicating information about the risks of treatment options.
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Have a documented process, screen instrument, or tool to assess patients' health literacy. • Have documentation of health literacy discussions in the patient record. • Have documentation of actions to build health literacy of patients in patient records.

▶ E	<p>Explanation</p> <p>Information provided to patients can be paper-based or online (eg leaflets, brochures, and links to reputable websites). The information needs to be in an appropriate language and format, which means using simple language, minimising jargon and complicated terms, and using clear diagrams.</p> <p>A process to understand the communication needs of patients is required, including consideration of:</p> <ul style="list-style-type: none"> • the patient's physical, visual and cognitive capacities, which may affect their ability to understand the information, make decisions, or provide consent • the way potentially sensitive information is communicated (eg about sexually transmitted infections, about blood-borne viruses, and pregnancy results) • the patient's cultural and linguistic background (eg you may need to use an interpreter to check that the patient understands everything that you have told them) • the patient's family members who are involved in their care • the patient's level of health literacy and therefore their ability to understand the information they receive • situations where patients are dependent on a third party for their ongoing care, as the carer needs to receive and understand all appropriate information. <p>Patients should be provided with information about their diagnosis, evaluation, treatment, and prognosis. When it is medically inadvisable to give this information to the patient, the information should be provided to a person designated by the patient or to a legally authorised person. The practice must obtain permission for a third party (eg interpreter or carer) to be included in consultations when the patient needs help to understand.</p> <p>It is important to discuss and explain treatment options and their possible risks or side effects. Patients have the right to refuse recommended treatment, advice, or a procedure, and to seek other clinical opinions from other healthcare providers. Any patient's refusal of any practitioner's advice must be documented in the patient record.</p> <p>Discussions between the care team and the patient regarding diagnosis, evaluation, treatment, and prognosis should be documented in the patient record and available to all members of the care team. The practice should also include evidence in patient records that clinical team members have informed patients of their own responsibility to comply with treatment plans.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Explain the diagnosis and treatment plan in an understandable, unrushed manner. • Provide evidence that enrolled patients are provided with information about their diagnosis, evaluation, treatment, and prognosis. • Document in the patient's record their consent to have a third party (eg interpreter or carer) to be included in consultations when the patient needs help to understand. • Document in the patient's record any refusal of the practitioner's advice. • Document discussions between the care team and the patient regarding diagnosis, evaluation, treatment, and prognosis. • Have a documented process to understand patients' communication needs. • Document in patient records that clinical team members have informed patients of their own responsibility to comply with treatment plans. • Use diagrams or flip charts in consultations to help explain diagnosis, evaluation, treatment and prognosis to patients. • Use tools that encourage shared decision-making to establish supportive and effective caring partnerships with patients. • Provide patients with information sheets and instructions about health conditions, treatments and medicines. • Have information relating to culturally specific health information (eg Aboriginal and Torres Strait Islander health) in the waiting room and consultation rooms. • Display posters containing information about, for example, specific diseases such as diabetes and chicken pox. • Use preventive health guidelines and resources. • Use clinical decision-making tools to work through treatment options with patients. • Refer patients to appropriate preventive health activities, such as diabetic education groups and groups to help patients quit smoking.
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Criterion 2.2 – Medical Home services and responsibilities

Indicators

- ▶ **A.** Our patients are provided with information and explanation regarding:
 - services offered by the practice
 - the role of the practice
 - the practice's approach to care
 - patients' rights, responsibilities and obligations.
- ▶ **B.** Administrative staff can explain to patients:
 - services offered by the practice
 - the role of the practice
 - the practice's approach to care
 - the care team's responsibilities and obligations.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>Practices should have a process to provide information to patients, carers and other relevant parties about:</p> <ul style="list-style-type: none"> • services offered by the practice • the role of the practice • the practice's approach to care • patients' rights, responsibilities and obligations. <p>Practices should consider providing information in a way that can be accessed by all patients, including those with low literacy, those who speak a language other than English, and those who do not have access to computers or the internet. This may mean using a number of methods to provide this information.</p> <p>Patients' rights, responsibilities and obligations should be documented in a patient agreement, which is signed by the patient (and carers if appropriate).</p> <p>If a carer has an ongoing role in the patient's day-to-day care, it is generally advisable to include the carer in the practitioner–patient relationship with the permission of the patient (if the patient is able to give such consent).</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.</p> <p>Items in red are mandatory.</p> <p>Items in black are optional.</p> <ul style="list-style-type: none"> • Provide evidence that patients can access information in format/s that are understandable about: <ul style="list-style-type: none"> – the role of the practice – the practice's approach to care – patients' rights, responsibilities and obligations – services offered by the practice. • Include information on patients' rights, responsibilities, and obligations in the patient agreement. • Create and maintain an up-to-date website that contains all the required information about the practice in language that is clear and easily understood. • Create and maintain an up-to-date information sheet that contains all the required information in language that is clear and easily understood. • Provide alternative ways to provide the information to patients who are unable to read or understand the information sheet. For example, pictures and versions in languages other than English. • In the waiting room, provide brochures and/or signs, written in languages other than English. • Use TV screens in the practice to show information about services provided.

► B

Explanation

Practices should have a process to provide information to the care team about:

- services offered by the practice
- the role of the practice
- the practice's approach to care
- the care team's rights, responsibilities and obligations.

Practices should consider providing information in a way that can be accessed and understood by all members of the care team, including those who are located outside of the practice. This may involve using a number of methods to provide information.

Demonstrating how you meet this Indicator

The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.

Items in **red** are mandatory.

Items in **black** are optional.

- Provide evidence that staff can access information in format/s that are understandable about:
 - the role of the practice
 - the approach to care
 - the care team's rights, responsibilities and obligations
 - services offered by the practice.
- In services agreements with members of the care team, include information about the care team's rights, responsibilities and obligations.
- Have a staff manual detailing the above information.
- Have an intranet where staff can access this information.
- Include information in staff induction.

Criterion 2.3 – Culturally and linguistically appropriate services

Indicators

- A. Our practice assesses the cultural and linguistic needs of its patients, carers and other relevant parties.
- B. Our practice meets the cultural and linguistic needs of its patients, carers and other relevant parties.

Meeting this Criterion

A	<p>Explanation</p> <p>The practice should have a process to determine the language needs of its patients and carers and other relevant parties.</p> <p>In addition, the practice should have a process to determine the cultural needs of its patients and carers and other relevant parties.</p> <p>The cultural needs of patients may include characteristics such as, but not limited to, religion, ethnicity, gender identity, and sexual orientation.</p> <p>Using data to identify the cultural and linguistic needs of its population will allow the practice to adequately meet the needs of its patient population. Patient data may be collected by the practice, or community level data may be provided to the practice by the relevant PHN.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.</p> <p>Items in red are mandatory.</p> <p>Items in black are optional.</p> <ul style="list-style-type: none"> • Have a process to determine the language and cultural needs of the practice's patients. • Collect patient data directly when patients enrol, using a patient admission form. • Collaborate with PHNs undertaking needs assessments to understand the needs of the practice's patient population.
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<p>B</p>	<p>Explanation</p> <p>It is important that there are practice processes in place to meet the cultural and linguistic needs of patients and carers and other relevant parties.</p> <p>Factors that may determine what is respectful and culturally appropriate care include:</p> <ul style="list-style-type: none"> • gender preference of patient • role of family • migration history • traditional health beliefs • history of traumatic events including, but not limited to, those associated with forced migration. <p>Interpreter and other communication services for patients who do not speak the primary language of the staff are critical ways of meeting diverse cultural and linguistic needs. Qualified medical interpreters are the preferred choice, other than in exceptional circumstances, such as medical emergencies. Aboriginal and Torres Strait Islander peoples may appear comfortable with English, but may still benefit from being offered an appropriate interpreter service.</p> <p>It is also important that staff use appropriate services to communicate with patients who have a communication impairment, except in exceptional circumstances.</p> <p>The practice could have a process to flag in the patient's record that they require an interpreter or other assistance with communication. This information should be accessible by all members of the care team.</p> <p>Providing patients with access to resources in languages other than English will assist. A directory of resources, services, online tools, and websites that facilitate or provide resources that translate information into languages other than English is also useful. These resources do not need to be hard copy or printed, as you may use them infrequently if your patient population is predominantly English speaking.</p> <p>Members of the practice should be aware of the importance of respectful, non-discriminatory and culturally appropriate care.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Document in the patient's record any translation services used. • Show that the practice's team members have a list of contact details of interpreter and other communication services. • Show that the practice's team members know how to contact and use services such as Auslan for patients who are hearing impaired. • Provide gender-specific practitioners when requested by patients, if possible. • Provide interpretation or bilingual services to meet the language needs of the practice's population. • Provide cultural safety training for team members and keep records of the training. • Maintain a cultural safety policy. • Maintain a list of websites or services where patients can access resources translated into their preferred language. • Maintain information sheets in the common languages of the patient population in the consultation spaces. • Maintain a patients' rights policy. • Maintain an anti-discrimination policy. • Discuss cultural safety in recruitment interviews. • Have separate entry and waiting rooms for men and women, if culturally appropriate. • Provide evidence of discussions the clinical team has had to identify the unique health needs of Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual (LGBTQIA) patients.

Criterion 2.4 – Care planning and self-care support

Indicators

- A. Our practice has a systematic process and criteria for assessing patients' health related risks and needs.
- ▶ B. The patient, the patient's preferred practitioner, the care team, carers and other relevant parties collaborate (at relevant visits) to develop and update care plans for enrolled patients.
- C. Our practice uses shared decision-making methods to involve each patient in the creation of their care plan.
- D. Our practice uses self-management tools in partnership with patients.

Meeting this Criterion

A	<p>Explanation</p> <p>Use of an approved risk stratification process will enable the practice to assess patients' health-related risks and needs. The assessment could be done using a simple screening tool that includes short questions about the following areas:</p> <ul style="list-style-type: none"> • diagnosis • previous medical history • socioeconomic and demographic factors • readiness to engage with the care process • resources available for care. <p>The data from the screening tool should identify the level of care support required. Patients should be stratified based on the complexity of their needs. Increasing complexity of their patient physical or mental health, such as more health conditions to manage at the same time (multimorbidity) or more severe symptoms, will require a greater level of support from health services.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Provide evidence of an approved risk stratification process to assess patients' health-related risks and needs.

► **B Explanation**

The patient's preferred practitioner should develop a care plan in partnership with the patient (and carer and/or family, if necessary) and other members of the care team who are responsible for the patient's care. The care plan should outline the patient's current and long-term needs and goals for care, identify coordination needs, and address potential gaps. The care plan should also explain how the patient will reach the goals and who is responsible for implementing each part of the plan (eg the GP, specific members of the care team, or the patient). The care plan anticipates routine needs, and tracks current progress towards the patient's goals.

The following steps will assist practitioners achieve the outcome:

- Consult with collaborating providers who will provide a different kind of treatment or service to the patient.
- Explain the steps involved in the development of the arrangements to the patient, and the patient's carer (if applicable, if the practitioner considers it appropriate, and if the patient agrees).
- Discuss with the patient the collaborating providers who will contribute to the development of the plan and provide treatment and services to the patient under those arrangements.
- Record the patient's agreement to the preparation and content of the plan.
- Record the plan in the patient's record.
- Give copies of the relevant parts of the plan to the collaborating providers.
- Offer a copy of the document to the patient and the patient's carer (if applicable, if the practitioner considers it appropriate, and if the patient agrees).

Patients and practitioners are required to sign the care plan to indicate that they have discussed and agreed with the content. The care plan should be reviewed and updated at regular intervals. The care team will determine when it is relevant to update the care plan.

Demonstrating how you meet this Indicator

The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.

Items in **red** are mandatory.

Items in **black** are optional.

- **Show individual care plans that include all required information and are signed by the patient/carers and members of the care team.**
- Provide evidence that the individual care plan has been reviewed and updated at required intervals.
- Provide evidence in the patient record and/or individual care plan of discussions between the practitioner and the patient or carer relating to the development of goals and progress towards goals.

<p>C</p>	<p>Explanation</p> <p>Using shared decision-making methods when writing and updating health plans in partnership with patients is critical.</p> <p>Shared decision-making involves integrating a patient's values, goals and concerns with the best available evidence about benefits, risks and uncertainties of treatment, in order to achieve appropriate healthcare decisions. It involves practitioners and the patient making decisions about the patient's management together.</p> <p>Shared decision-making helps patients make decisions about their own healthcare³ and can improve satisfaction with care and lead to better decisions. Using shared decision-making methods improves patients' knowledge of their options, gives them more accurate expectations of possible benefits and harms, and promotes a feeling of greater participation in decision-making. Patients who are better informed make different, often more conservative and less costly choices about treatment, because they have a realistic appreciation of likely benefits and risks of treatment and can consider potential outcomes.</p> <p>In partnership with their practitioner, patients should be encouraged to consider available screening, treatment, or management options and the likely benefits and harms of each, share their preferences, and help select the best course of action.</p> <p>Shared decision-making methods could be undertaken during the usual process of providing care and therefore does not always require the use of decision-making aids. However, various types of decision support aids are available to facilitate the process of shared decision-making.³ Ultimately, the care team's objectives are to deliver healthcare in a consultative way, and to ensure the patient understands the care they receive and play a role in deciding what approach to their healthcare best suits their needs.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Demonstrate that the care team is using shared decision-making methods. These methods should be chosen to suit the needs and preferences of the care team and the patients. • In the patient's record and patient individual care plan, record the patient's preferences as discussed during the consultation. This could be the patients' general preferences for healthcare or preferences about a particular condition. • Have a list of key questions that the care team has found useful in facilitating and guiding shared decision-making. • Use tools and resources to assist communicating patients' health status and treatment options. • Provide educational materials and resources to the patient, and record this in the patient's care plan/patient record. • Develop and use a suite of shared decision-making aids that suit the needs of both the patient and care team.

<p>D</p>	<p>Explanation</p> <p>Self-management support is the help given to people with chronic conditions that enables them to manage their health on a day-to-day basis.⁴ Self-management support can help and inspire people to learn more about their conditions and to take an active role in their healthcare.</p> <p>Self-management strategies complement a patient-centred approach and have been found to be effective for different groups of patients (eg disadvantaged people), preventive strategies, and chronic diseases including diabetes, asthma, chronic back pain, and chronic obstructive airways disease.⁴</p> <p>Self-management principles include:</p> <ul style="list-style-type: none"> • engaging the patient in decision-making and management of their illness, including setting appropriate goals • using evidence-based, planned care • improving patients' self-support (eg enlisting other health professionals and supports, and improving links with community resources such as seniors centres, self-help groups, skills and support programs) • a team approach to managing care. <p>The care team can assess how ready the patient is to integrate self-management into their individual care plan. If appropriate, the care team could provide the patient with support around commencing self-management strategies.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Document the assessment of the patient's readiness to integrate elements of self-management into their individual care plan. • Document the self-management plan (as agreed by the patient and the care team) in the patient's individual care plan. • Provide patients with self-management tools to record self-care results. • Refer patients to structured health education programs, such as group classes and peer support or community services. • Maintain a current resource list of key community services that are appropriate to the patient population, including services offered outside the practice and its affiliates. • Assess the usefulness of identified community resources.

Criterion 2.5 – Management of medication and treatment

Indicators

- ▶ **A.** Our clinical team reviews all medications for enrolled patients at least annually.
- B.** Our clinical team provides information and facilitates the understanding of new treatments to patients.
- C.** Our clinical team assesses patients' responses to treatments.
- D.** Our clinical team assesses patient barriers to treatment adherence.
- E.** Our clinical team documents patients' use of over-the-counter medications, herbal therapies, and supplements at least annually.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>It is important to document in the patient record all prescribed medications that the patient is taking.</p> <p>A review of medication needs to occur at least annually, including at transition of care and at relevant visits. The practice needs to keep documentation relating to medication reviews in the patient's record, including information given to the patient about the purpose, importance, benefits, and risks of their medicines.</p> <p>A pharmacist could be included within the care team to conduct medication reviews.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.</p> <p>Items in red are mandatory.</p> <p>Items in black are optional.</p> <ul style="list-style-type: none"> • Provide an up-to-date list in the patient record of all prescribed medications the patient is taking. • Keep documentation relating to medication reviews conducted at least annually in the patient record, including information given to the patient about the purpose, importance, benefits, and risks of their medicine.

<p>B</p>	<p>Explanation</p> <p>Providing information about treatments, including medicines and medicine safety, non-drug therapies, and procedures, may help patients to make informed decisions about their healthcare. For this reason, the care team can consider:</p> <ul style="list-style-type: none"> • checking patients' understanding of what the treatment is • offering to discuss any issues about a patient's condition, proposed treatment, and medicines that could be confusing • directing patients to reliable health and medicine websites where they can find further information • advising patients to seek further advice about their medicines from their pharmacist. <p>It is important the practitioners explain treatment options in language that patients understand. The care team should assess the health literacy of a patient to ensure that the patient is fully aware of and understands treatment options and the possible risks or side effects of medications and other treatments.</p> <p>Patients have the right to refuse a recommended treatment, advice, or procedure, and to seek clinical opinions from other healthcare providers. It is advisable to document any patient's refusal of any practitioner's advice in the patient record.</p> <p>Discussions between the care team and the patient regarding diagnosis, evaluation, treatment, the patient's responsibilities, and prognosis should be documented in the patient record, and this information should be available to all members of the care team.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • In the patient record, document discussions regarding new treatments. • In the patient record, document the information given to the patient about the purpose, importance, benefits, and risks/side effects of their treatments. • In the patient record, document the patient's refusal of any practitioner's advice. • Provide evidence that patients have access to information about treatments. • Show that patients have access to videos, brochures, and posters about medicines and other treatments. • In the patient record, document that clinical team members have informed patients of their own responsibility to comply with treatment plans. • Document discussions regarding medications between patients and pharmacists who are part of the care team, if relevant. • Carry out a Home Medicines Review (HMR).

<p>C</p>	<p>Explanation</p> <p>At regular intervals, it is important that the care team assesses patients' responses to treatments. The practice can determine how often this takes place on a case-by-case basis. As part of this process, the care team can talk with the patient to determine whether the patient feels the treatments are working and how well the treatments are being tolerated.</p> <p>Discussions regarding a patient's response to treatments will cover:</p> <ul style="list-style-type: none"> • side effects • allergies • adverse events • alternatives. <p>Any changes to medications or treatments should be documented in the patient record.</p> <p>Suggested follow-up appointments should also be documented in the patient information system and the patient record.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Document discussions regarding a patient's response to treatments that include: <ul style="list-style-type: none"> – changes in health condition – side effects – allergies – adverse events – options for alternatives – any changes to medications or treatments. • Document follow-up appointments in the patient record.

<p>D</p>	<p>Explanation</p> <p>The treatment of health conditions, particularly complex or chronic conditions, requires the patient to adhere to treatments as prescribed by the care team.</p> <p>Barriers to adherence include:</p> <ul style="list-style-type: none"> • physical (access to services and transport) • poor health literacy • financial hardship • lack of involvement in decision-making • ineffective communication (between patient and care team, and among the care team) • the patient's healthcare preferences • the patient's motivation. <p>The care team needs to discuss any anticipated barriers to treatment adherence with the patient, and collaborate to develop ways to overcome these barriers.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • In the patient record, document discussions regarding a patient's response to treatments, including: <ul style="list-style-type: none"> – side effects – allergies – adverse events – options for alternatives. • In the patient record, document any changes to medications or treatments. • In the patient record, document discussions between patients and pharmacists who are part of the care team regarding medications, treatment options, and alternatives. • In the patient record, document discussions regarding alternative treatment options or dosages. • In the patient record, document discussions of any barriers to treatments and proposed solutions.
<p>E</p>	<p>Explanation</p> <p>At least annually, the practice should review and document in the patient record the non-prescription medications, such as over-the-counter (OTC) medications, herbal therapies, and supplements that the patient is taking, in order to prevent interference with prescribed medications.</p> <p>Any changes to OTC medications are to be included in the patient's medicines list.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Document in the patient record an up to date list of OTC medications, herbal therapies and supplements the patient is taking. Review this list at least annually.

Standard 3: Coordinated care

Coordinated care where care is planned and coordinated across healthcare settings to maximise positive outcomes.

Criterion 3.1 – Continuity of care

Indicators

- ▶ A. Our enrolled patients have a preferred practitioner.
- ▶ B. The care team are aware of enrolled patients' preferred practitioner.
 - C. Our practice has a process for patients to see their preferred practitioner.
 - D. Our practice records how frequently a patient sees with their preferred practitioner.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>All patients enrolled in the practice need to nominate their preferred practitioner, and should also nominate a second practitioner who they would choose to see if their preferred practitioner is not available.</p> <p>The name of the preferred practitioner and the secondary practitioner should be recorded in the patient record and available to all members of the care team.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • In the patient record, document the name of the patient's preferred practitioner. • In the patient record, document the name of the patient's secondary practitioner, if relevant.
▶ B	<p>Explanation</p> <p>All members of the care team need to be aware of the patient's preferred practitioner.</p> <p>All tests and investigations should be copied to the patient's preferred practitioner. All documentation sent from external members of the care team to the practice should also be directed to the patient's preferred practitioner.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • In the patient record, document the name of the patient's preferred practitioner. • In the patient record, document the name of the patient's secondary practitioner. • Show patient records that demonstrate that patients consistently see the same practitioner. • In the patient record, document tests and investigations ordered by the patient's practitioner. • Demonstrate that members of the care team can find out who the patient's preferred practitioner is when asked.

C	<p>Explanation</p> <p>It is important that the practice has processes that enable patients to see their preferred practitioner whenever possible.</p> <p>If a practitioner is going on leave, it is good practice to inform patients. This may be done by displaying notices in the waiting room that include the date the practitioner is due to return, or informing patients directly via phone call, email or mail.</p> <p>If the patient sees a practitioner other than their preferred practitioner, the reason for this should be recorded in the patient record.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Document a process for patients to see their preferred practitioner when possible. • Show patient records that demonstrate that patients consistently see the same practitioner. • In the patient record, document why a patient has seen another practitioner. • Provide notices in the waiting room when a practitioner is on leave.
D	<p>Explanation</p> <p>Practices should have a process to record and review which practitioner a patient has seen. Practices can review this information to determine the proportion of visits that the patient has seen their preferred practitioner.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Demonstrate that the practice has a system to record and review which practitioner a patient has seen.

Criterion 3.2 – Coordination of care

Indicators

- ▶ **A.** Our practice plans patient care, manages care transitions, and coordinates care with other services for enrolled patients, such as:
 - medical services, including diagnostic services, hospitals, and specialist consultant services
 - mental health services
 - primary healthcare nurses
 - allied health services
 - pharmacists
 - disability and community services
 - health promotion and public health services and programs.
- B.** For patients who are regularly treated by a specific specialist outside of the care team, our practice documents co-management arrangements in the patient record.
- C.** Our practice identifies patients who have had unplanned hospital admissions and visited emergency departments.
- D.** Following a patient's hospital admission or emergency department visit, our practice proactively contacts the patient/carer to arrange appropriate follow-up care.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>Coordinating patient care across multiple settings includes communicating with patients/carers and the care team. Coordination of care involves the following tasks (as outlined by the Agency for Healthcare Research and Quality):⁵</p> <ol style="list-style-type: none"> 1. Determining and updating care coordination needs <p>Care coordination needs are based on a patient's healthcare needs and treatment recommendations, which reflect physical, psychological, and lifestyle factors. Care coordination needs are also determined by the patient's current health and health history, self-management knowledge and behaviours, and needs for support services. The assessment of care needs and care coordination needs should identify the patient's preferences and goals for healthcare. The assessment should be updated periodically and after new diagnoses or other changes in health.</p> 2. Communicating <p>Exchange information, preferences, goals, and experiences with the care team. Communication could be in person, over the phone, in writing, or a combination.</p> 3. Facilitating transitions <p>Transitions require transfer of both accountability and information. This is especially critical when care moves between distinct settings, such as during a hospital discharge. The care coordinator is responsible for coordinating patient appointments between members of the care team.</p> <p>Practices must use a shared electronic health record system for all enrolled patients. It is important that all members of the care team can access this system so that up-to-date information can be recorded and shared.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Have signed agreements between the practice and members of the care team. • Have evidence of a shared electronic health record system for all enrolled patients that all members of the care team can access. • In the patient record, document receipt of discharge summaries and specialist reports. • In the patient record, document follow-up appointments with the patient. • Have signed agreements with local hospitals, if relevant.

B	<p>Explanation</p> <p>For patients who are regularly treated by a specific specialist who does not belong to the care team, it is good practice for the patient's primary practitioner and the specialist to enter into an agreement that enables co-management of the patient's care. This agreement could include timely sharing of changes in patient status and the treatment plan, as well as information that is to be entered in the patient record within an agreed period.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Have signed agreements between the patient's practitioner and other specialists who are not members of the care team, outlining the roles and responsibilities in the co-management of the patient. • Provide evidence that the patient's practitioner and other specialists who are not members of the care team have developed and regularly reviewed the patient's individual care plan. • Establish preferred methods of communication between the patient's practitioner and other specialists who are not members of the care team.
C	<p>Explanation</p> <p>It is important for continuity of care that the practice identifies patients who were hospitalised or had emergency room visits.</p> <p>The practice can achieve this by collaborating directly with local hospitals, and implementing notification systems for enrolled patients who are admitted or discharged from hospital.</p> <p>Practices could also include in the patient agreement that the patient will notify the practice of any hospital presentations or admissions as soon as practical.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Have a process for identifying patients who have had an unplanned hospital admission or emergency department visit. • Have follow-up processes for patients who have been identified as having had an unplanned hospital visit. • Formalise a process to receive information from local hospitals. • Have signed patient agreements that require the patient to contact the practice in the event of an unplanned hospitalisation or emergency department visit.
D	<p>Explanation</p> <p>Practices should consider contacting patients/carers for appropriate follow-up care after a hospital admission or emergency department visit.</p> <p>Proactive contact includes offering patients appropriate care to prevent worsening of their condition, and encouraging follow-up care. In addition to scheduling an appointment, follow-up care can include referrals to other members of the care team or discussions regarding self-management methods.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Have a follow-up process for patients who have been identified as having a hospital visit. • Show that follow-up appointments are documented in the patient record. • Show that modifications to treatment plans in response to hospitalisations are documented in patient records, if relevant.

Criterion 3.3 – Test tracking and follow-up

Indicators

- ▶ A. Our practice has a documented process for test tracking and follow-up for enrolled patients.
- ▶ B. Pathology results, imaging reports, and investigation reports received by our practice are:
 - reviewed by a practitioner
 - electronically notated, or, if on paper, signed or initialled
 - acted on where required
 - added to the patient record.
- ▶ C. Our practice recalls patients with clinically significant results.
- ▶ D. Our patients are advised of the process for follow up of tests and results.
- ▶ E. Our practice initiates and manages patient reminders.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>After a practitioner has explained and advised a patient of tests or other action required, and the patient has understood this advice, it is up to the patient to decide if they are going to follow the recommendations. Some patients do not follow recommendations due to, for example, their particular circumstances, fear, ignorance, personality traits, expectations, beliefs, or cultural backgrounds.⁶</p> <p>Practices should have safeguards that ensure that potentially clinically significant information does not get ‘lost in the system’. This may include a statement in the agreement between the patient and the practice that patients are responsible for having the recommended tests performed and for obtaining the results.</p> <p>Practices need to track tests and investigations from the time they are ordered until results are available, and flag test results that have not been made available. The flag may be an icon that automatically appears in the electronic system or a manual tracking system. The practice should follow up with the lab or diagnostic centre (and the patient, if necessary) to determine why results are overdue.</p> <p>If a member of the care team located outside the practice has ordered a test, then that practitioner has primary responsibility to follow up the test and the result. The patient’s primary practitioner should be copied into test results and be aware of any subsequent action.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Have a documented process to track tests and investigations until results are available, flagging and following up on overdue results. • Have a documented process to follow up with the patient within a certain period to determine if they have had the test. • In the patient record, document why the patient has chosen not to have the test.

▶ B	<p>Explanation</p> <p>It is important that practitioners review results and reports and take appropriate action in a timely manner. The speed with which results/reports are acted on and the effort taken to contact the patient to discuss the results will depend on the practitioner's judgement of the clinical significance of the result/report.</p> <hr/> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none">• Show that pathology and other test results are added to the patient record.• Ensure that pathology results in patient records show evidence of review by a practitioner as required.• Have a documented process for the review and management of results received by the practice.• Have a policy addressing the review and management of results.
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▶ C	<p>Explanation</p> <p>The practice needs to have a process for recalling patients. A recall occurs when a practitioner decides that a patient needs to be reviewed within a specified period. For example, a patient might be recalled:</p> <ul style="list-style-type: none"> • when the practice receives a clinically significant test result • after significant referrals, such as after they have seen a psychologist or psychiatrist for a mental health assessment • after diagnosis of significant conditions, such as type-2 diabetes. <p>Ideally, the recall process will be outlined in a written policy for team members to follow, and could include:</p> <ul style="list-style-type: none"> • a definition of 'clinically significant results' • a statement that responsibility for reviewing results and identifying them as clinically significant rests with the practitioner • how to recall a patient, clearly outlining the roles and responsibilities of different team members, including the information different team members can convey, and how to convey it. For example, if reception staff are responsible for contacting patients with significant results to make an appointment, explain how they could do this (eg 'Your doctor wants you to make an appointment this week to discuss the results of your recent tests') • guidelines about what information needs to be recorded (eg clinical discussions and outcomes) in patient records • standard forms and letters for recalling patients • who is responsible for monitoring and following up recalls. <p>If using a system for billing and appointments that is separate from the clinical information system, make sure the systems allow the exchange of follow-up information where required. Some software allows you to flag recall appointments if the patient does not return within the expected time.</p> <p>In the patient record, document attempts to contact and recall patients about clinically significant tests and results.</p> <p>The follow-up system needs to accommodate different levels of follow-up, depending on the patient's needs and clinical significance of the case. Consider the following factors to determine if a result is clinically significant and therefore requires action:</p> <ul style="list-style-type: none"> • the probability that the patient will be harmed • the likely seriousness of the harm • the burden of taking steps to avoid the risk of harm. <p>The clinical significance of a test or result should be considered in the context of the patient's history and presenting problems. 'Clinically significant' does not necessarily mean only 'abnormal' results. The practitioner determines a result as clinically significant for a particular patient in the context of that patient's healthcare. While a practitioner will generally decide that an abnormal result is clinically important and requires further action, they may also decide that a normal result requires further action.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Have a documented recall policy and process (including who is responsible for monitoring and follow-up) for team members. • Ensure patient records show attempts to contact and recall patients about clinically significant tests and results. • Ensure patient records show when follow-up has occurred and the treatment, if any, that is required. • In staff position descriptions, include responsibilities for recalling patients. • In a clinical information system, have processes set up to trigger recalls. • Demonstrate how recalls are sent via the clinical information system. • In the patient record, document conversations about test results.
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▶ D	<p>Explanation</p> <p>Practices should initiate follow-up contact with a patient in a reasonable manner, taking into account all circumstances to determine the number, frequency, and nature of the attempts to contact the patient. For example, it would be good practice to make up to three telephone calls at different times of the day and then attempt to contact the patient by mail or email. Document each attempt in the patient's record.</p> <p>The ability for practices to identify significant results when they are received is important for continuity of patient care. Consider how to sensitively inform the patient, who may not anticipate or understand the significance of the result.</p> <p>When explaining test results to the patient, make sure the explanation is clear and that the patient understands what you are telling them. A patient who makes a decision based on insufficient or unclear information is not making an informed decision. When the patient fully understands the information, they can give legally effective informed consent, or exercise their right to a legally effective informed refusal.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Ensure patients are advised of the process to receive results. • Ensure patient records show when follow-up and treatment, if required, has occurred. • In patient records, document conversations about test results. • Have a team member who is responsible for the recall process. • Have processes set up in the clinical information system to trigger recalls and reminders.
E	<p>Explanation</p> <p>Reminders help to manage preventive care, and can be set up before or during a consultation by noting in a patient's record when the patient is due to return for a routine check. Reminders help to ensure that patients have preventive health checks. For example, the practice can send an email, letter or SMS to:</p> <ul style="list-style-type: none"> • patients in the high-risk age bracket for influenza, prompting them to come in for a vaccination • patients who are due for a routine Pap smear or breast screening test. <p>Consider using the clinical information system to automatically generate SMSs, emails, or letters to issue reminders. Some software will display a prompt when a patient's record is opened, informing the practitioner that the patient is due for a preventive or clinical activity.</p> <p>If the patient does not make an appointment after the practice has sent a reminder to them, the practice is not obliged to follow up. However, it is good practise to record the reminder in the patient's record.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Have a documented process for initiating and managing reminders. • Ensure team members can explain the process for sending out reminders to patients. • Ensure patient records show when reminders have been initiated and acted upon. • Have processes set up in the clinical information system to trigger recalls and reminders. • Demonstrate how reminders are sent via the clinical information system.

Criterion 3.4 – Referral tracking and follow-up

Indicators

- ▶ A. Our practice's referral letters contain all required information.
- ▶ B. Our practice tracks referrals for enrolled patients until the consultant's or specialist's report is available, flagging and following up overdue reports.
- ▶ C. Clinical correspondence received by our practice is:
 - reviewed
 - electronically notated, or, if on paper, signed or initialled
 - acted on where required
 - incorporated into the patient record.
- D. Our practice asks patients/carers about self-referrals and requests reports from practitioners.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>Referral letters are critical to integrating the care of patients with external healthcare providers.</p> <p>Referral letters should:</p> <ul style="list-style-type: none"> • be legible • identify the practitioner making the referral and the healthcare setting from which the referral has been made (eg the general practice or Aboriginal Medical Service) • identify the healthcare setting to where the referral is being made (eg the specialist consultancy) • include the name of the care team member to whom the referral is being made • include the patient's name and date of birth and at least one other patient identifier • explain the purpose of the referral • include the urgency of the referral in concrete terms and the reasons for an urgent visit • indicate the type of referral, which may be a consultation or single patient visit, a request for shared management of the patient for a specific condition for a specified or indefinite time, or a request for temporary or long-term principal care, such as a transfer • include details of the current care plan • contain enough information (the relevant history, examination findings, and current management) so that the other healthcare provider can provide appropriate care to the patient, but not include sensitive patient health information that is not relevant to the referral • include a list of known allergies, adverse drug reactions, and current medicines • include any culturally appropriate information to facilitate culturally safe care by other health service providers (eg the need for an interpreter). <p>A copy of the referral letter needs to be included in the patient record.</p> <p>In the case of an emergency or other unusual circumstances, a telephone referral may be appropriate. Written notation of telephone referrals must be made in the patient's record.</p> <p>If your practice wants to send referrals electronically, it is important to obtain patient consent beforehand.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Provide evidence of referral letters in patient records. • Have a standard referral template that includes all relevant details. • Have a policy on referral documents, which includes the need to include at least three patient identifiers. • Have a procedure for gaining consent from patients when referrals are sent electronically. • In the practice's privacy policy, include relevant information about electronic transmission of referrals

▶ B	<p>Explanation</p> <p>Tracking and supporting patients when they obtain services outside the practice, and ensuring appropriate and timely referrals or transitions, is fundamental to the success of the Medical Home model.</p> <p>Practices need to track referrals from the time that they are requested until a report is available. If a report has not been received within the expected time, practices should flag that the report has not been received. The flag may be an icon that automatically appears in the electronic system or a manual tracking system. Practices should have a process to ensure that they obtain the report.</p> <p>Practices could use a tracking log to track referrals. A tracking report includes the date on which a referral was initiated, the date when you expect to receive the report, and the date on which you receive the report. If you do not receive a report, you should contact the referred practitioner's office, and document your efforts to obtain the report.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Document a procedure for tracking referrals and an example of how the procedure has been followed. • Provide a tracking log showing data collected in the tracking system. • Show received specialist reports in the patient record. • Document conversations about seeking referral reports in the patient record.
▶ C	<p>Explanation</p> <p>Practitioners need to review clinical correspondence and reports following referrals, and take appropriate action in a timely manner. The speed with which the practice responds to clinical correspondence/reports following referrals, and the effort taken to contact the patient to discuss the results, will depend on the practitioner's judgement of the clinical significance of the report, and the context and duration of the clinical relationship.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Show that clinical correspondence and reports following referrals are added to the patient record. • In patient records, ensure that there is evidence that a practitioner has reviewed clinical correspondence and reports following referrals. • Have a documented process for the review and management of clinical correspondence and reports following referrals.
D	<p>Explanation</p> <p>Patients might see specialists without a referral from the practice and without the knowledge of the practice or the patient's preferred practitioner.</p> <p>Practices could routinely ask patients if they have seen a specialist, allied health professional or other health professional outside of the practice's care team. If the patient is seeing another health professional, the practice should request a report from that health professional. This request and report should be included in the patient record.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • In the patient record, document conversations about any patient self-referrals. • In the patient record, include relevant reports from health professionals that the patient has self-referred to.

Standard 4: Comprehensive preventive, acute and chronic disease care

Comprehensive care that meets the majority of a patient's needs.

Criterion 4.1 – Patient records

Indicators

- ▶ **A.** A. Our practice has an individual patient health record for each patient containing all health information held by our practice. This information could include:
 - identification details, contact details, demographic, next of kin, and emergency contact information
 - allergies
 - adverse drug reactions
 - current health problems
 - summary of significant past health problems
 - relevant family and social history
 - identification of Aboriginal and/or Torres Strait Islander status
 - cultural backgrounds
 - any relevant preventive care information collected, such as currency of immunisations, blood pressure, waist measurement, height and weight (body mass index)
 - wellness care discussions, including healthy lifestyle issues (eg sleep, stress relief, weight management, healthy diet, oral care) as appropriate
 - health risk appraisal and health risk assessment, and relevant discussions with the patient
 - screening
 - recommended management plan and, where appropriate, expected process of review
 - current medicines list that includes the name, strength, directions for use, dose frequency, number of repeats, and the date on which the patient started/ceased/changed the medication
 - complementary medicines the patient takes
 - referrals to other healthcare providers or health services
 - end-of-life care
 - after-hours appointments
 - missed appointments
 - hospitalisations.
- B.** Our practice uses documented clinical terminologies and classifications.

Meeting this Criterion

<p>► A</p>	<p>Explanation</p> <p>Members of the care team should update patient records as soon as practicable during or after consultations and visits. Recording the identity of the person in the care team updating the patient record is an important part of the process.</p> <p>All patient records, including scans of external reports, must be legible so that another practitioner could take over the care of the patient if needed.</p> <hr/> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Show that patient records contain all required information. • Show entries in the patient record for each appointment. • Demonstrate that the shared electronic patient record system used by the practice can be accessed and updated by all members of the care team. • Regularly conduct a practice audit on patient health records to ensure compliance.
<p>B</p>	<p>Explanation</p> <p>Clinical terminologies and classifications allow the details of a consultation to be recorded in a standardised way. This can include information such as why a patient comes for treatment, the problems managed during a consultation, referrals, and investigations requested. Data can then be retrieved regarding patient appointments for auditing, quality improvement, and continuity of care purposes. Using recognised classifications and terminology avoids confusion that can result from entering 'free text' in a patient's medical record.</p> <p>Nationally recognised coding systems, such as the International Classification of Primary Care (ICPC) and SNOMED CT, are effective in ensuring that data is recorded consistently, and can be used across a range of settings including chronic disease registers and population health research. Some clinical information systems will also allow you to use a system that uses drop-down boxes so that only pre-defined selections can be made.</p> <p>Most clinical information systems for general practices in Australia (including DOCLE, PYEFINCH, SNOMED-CT, and ICPC2+) use a recognised medical vocabulary. Nationally recognised disease classification and terminology systems include ICPC2 and SNOMED-CT.</p> <p>Not all clinical information systems have inbuilt coding. If your software does not allow coding to be included easily, you could consider another method or system to include recognised classifications and terminology in your patient records.</p> <p>Coding does not necessarily need to replace details in past medical histories that have been recorded in free text, but can be a useful addition to a past medical history, particularly if there are important details in a patient's past medical history that may be difficult to formally code.</p> <hr/> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Show that documented clinical terminologies are recorded in the clinical information system. • Use clinical information systems to code patient health information. • Keep clinical data and reports, including rates of childhood vaccinations, completed adult health checks, and updated risk factors.

Criterion 4.2 – Evidence-based care

Indicators

- **A.** Our clinical team is able to access relevant current clinical guidelines and other guidelines that help diagnose and manage our patients.

Meeting this Criterion

► A	<p>Explanation</p> <p>Clinical practice guidelines provide important recommendations for clinical care. Guidelines need to be accessible when providing healthcare, so the practice can provide consistent and tailored healthcare, based on community and patient demographics.</p> <p>Consistently applying clinical guidelines helps to:</p> <ul style="list-style-type: none"> • provide consistent diagnoses and consistent management of health issues and minimise variation of care between practitioners • provide continuity of care to each patient • give each patient clear and consistent messages about their health issues and treatment. <p>In addition, patients value consistency in the quality of treatment and advice given by different practitioners in the practice.</p> <p>It is important to ensure that clinical practice guidelines are current, reflect best evidence, and are accessible, whether online or paper-based. When clinical teams discuss clinical care, they should compare the outcomes of their discussions with the best available evidence, to ensure that their clinical care aligns with best practice.</p> <p>Good communication between members of the clinical team can help to ensure a consistent approach to clinical care. Although face-to-face meetings of the clinical team are preferred, communication tools such as message systems and notice boards can be useful to raise and address clinical issues.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Ensure that all members of the practice team have access to current clinical guidelines. • Ensure that the clinical information system is regularly updated to the most recent version. • Have regular clinical team meetings or regular electronic discussions (eg via email), and document the topics of discussion and the decisions made. • Keep records of clinical team meetings that are about the use of clinical guidelines. • Establish and maintain a system that team members can use to pass on information (eg a communication book, internal mail, and an email system). • Ensure that members of the care team know the specific clinical guidelines to use for patients who identify as of Aboriginal or Torres Strait Islander descent, how to access those guidelines, and how to use them to support care, including the prevention and management of chronic diseases.

Criterion 4.3 – Clinical indicators

Indicators

- A. Our practice regularly collects data for a nationally and/or regionally consistent de-identified data set.
- B. Our practice undertakes and regularly updates a comprehensive health assessment for each patient.

Meeting this Criterion

A	<p>Explanation</p> <p>It is important that a consistent, de-identified data set is collected and used at a regional and/or national level to understand the impact of the Medical Home model. This data can then be used to make system-level changes with a view to improving population health outcomes and informing ongoing health system improvements.</p> <p>Data collection and analysis should be conducted by the medical homes and related services, as the data will help to identify the impact of the new models of primary and integrated care, and progressively improve the quality of care.</p> <p>Data could be collected from the following categories:</p> <ul style="list-style-type: none"> • diabetes • COPD • ischemic heart disease • blood pressure • bowel screening • cervical screening • asthma • allergies. <p>Practices should use a practice management, electronic patient record, or other electronic system that records patient information in searchable data fields. Searchable data is information entered into a field in an electronic system that is used to search for data and create reports. This data should be able to be de-identified and extracted from the electronic system into meaningful reports that can be reviewed and analysed by members of the practice.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Use an electronic system that records patient information for the required areas in searchable data fields. • Generate and keep reports for each area showing the percentage of the practice's patients that fall into each area.

B	<p>Explanation</p> <p>A standardised, comprehensive patient assessment includes an examination of lifestyle risk factors as well as physical risk factors. The care team can decide how frequently it conducts and updates health assessments.</p> <p>Assess risk factors for:</p> <ul style="list-style-type: none"> • asthma • cancer • cardiovascular disease • diabetes • mental health conditions • arthritis • musculoskeletal conditions. <p>Assess lifestyle risk factors, such as:</p> <ul style="list-style-type: none"> • smoking • nutrition • use of alcohol and other substances • physical inactivity • moods. <p>Assess biomedical risk factors, such as:</p> <ul style="list-style-type: none"> • blood pressure • body weight • high cholesterol • impaired glucose metabolism • urinalysis. <p>Documentation of these assessments should be noted in the patient record.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.</p> <p>Items in red are mandatory.</p> <p>Items in black are optional.</p> <ul style="list-style-type: none"> • Show that comprehensive risk assessments are documented in the patient record.

Standard 5: Accessible care

Accessible care, available to patients easily, when it is needed, and in responsive settings.

Criterion 5.1 – Accessible appointments

Indicators

- ▶ A. Our practice provides enrolled patients with flexible care arrangements.
- ▶ B. Our practice provides enrolled patients with access to after-hours care.
- ▶ C. Our practice provides after-hours providers with access to patient information for urgent care and advice outside our opening hours.
- ▶ D. Our patients have access to home-visits.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>It is important that enrolled patients are able to access care that is flexible and accommodates their needs. This includes the provision of different types of consultations (eg long or short), different types of care (eg complex care, preventive care), and different levels of access (eg appointment-based systems or walk-in services) based on patients' needs.</p> <p>Offering alternative types of clinical encounters for patients who are unable to physically attend the practice is also important. These could include phone, email, video, or online consultations, telehealth, and home visits.</p> <p>Considerations for practitioners when conducting technology-based consultations include:</p> <ul style="list-style-type: none"> • confirming the identity of the patient using three patient identifiers • advising patients of the security risks associated with unencrypted email • obtaining the patient's prior written consent, preferably before the consultation takes place. <p>A written process is recommended that covers how the practice determines what kind of appointments to provide under different circumstances.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Show evidence that enrolled patients are prioritised according to urgency of medical need. • Keep an appointment system that records the appointment types, such as: <ul style="list-style-type: none"> – long appointments – short appointments – walk-in appointments – recall appointments – reserved appointment times for urgent appointments on the day. • Offer an alternative type of clinical encounter for enrolled patients. • Offer technology-based consultations. • Display a sign in the patient waiting area that explains short, standard, and long appointments. • Display a sign on the front of the clinic that has contact details of emergency care that is available outside normal opening hours.

► B	<p>Explanation</p> <p>Practices need to inform patients of normal opening hours and the arrangements for care outside those hours. Patients can be informed of the out-of-hours arrangements using one or more of the following:</p> <ul style="list-style-type: none"> • an out-of-hours message on the practice's telephone • the practice's website • the practice's collateral, including leaflets, newsletters and new patient information pack • a clearly visible sign on the outside of the front door of the practice. <p>The practice may deliver after-hours care for patients, either during 'sociable hours' or during 'sociable and unsociable hours'.</p> <p>If the practice cannot provide after-hours care for its patients, it could participate in a cooperative arrangement with another practice to deliver after-hours care.</p> <p>After-hours care may also be performed on behalf of the practice by an external agency such as a Medical Deputising Service (MDS). When this occurs, there must be a direct and continuing relationship between the practice's practitioners and the practitioners who perform after-hours care on their behalf. If you use other services to provide after-hours care, you should have evidence showing:</p> <ul style="list-style-type: none"> • details of the arrangements • how and when you receive documentation and information about care provided to patients outside normal opening hours • how the providers of after-hours care can contact the practice in an emergency or when there are exceptional circumstances. <p>If you have arrangements with any after-hours providers, you should give the provider the after-hours contact details of one or more of your practitioners, so that they can access important information about the patient when required, particularly in an emergency.</p> <p>It is important that notes from after-hours consultations are added to the patient record.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Show that patient records have either the actual or scanned treatment reports from practitioner(s) that have provided after-hours care. • In patient agreements, include details about after-hours care arrangements. • Show that team members are able to explain how patients can access care after hours. • Have signed agreements between the practice and the practitioners or organisation that provides after-hours care for the practice's patients (if relevant). • Display signs in the waiting area and on the outside door that explain how patients can access after-hours care. • Maintain an after-hours voicemail message that clearly states how patients can access after-hours care. • If the practice provides after-hours care for another health service, ensure that you have contact details for that health service if you need to contact them about one of their patients in an emergency.

<p>► C</p>	<p>Explanation</p> <p>Practices need to provide after-hours providers access to patient records in urgent circumstances.</p> <p>The practice should explain to doctors who provide after-hours care what they should do when they receive urgent and/or life-threatening results about the practice's patients. After-hours services have a responsibility to contact the practice if they receive seriously abnormal or life-threatening results outside normal opening hours. This should be explained in an agreement between the practice and the service providing after-hours care.</p> <hr/> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Have signed agreements between the practice and the practitioner or organisation who perform after-hours care for the practice's patients, that include how health records are accessed in urgent circumstances after-hours. • Have a process that explains how high-risk results identified outside opening hours are to be managed. • Ensure diagnostic services have the contact details of the practitioner who ordered the investigation. • Ensure pathology providers can contact the practice staff who have access to patient records when high-risk results are received after-hours. • Ensure that the contact details supplied to diagnostic services are current and correct.
<p>► D</p>	<p>Explanation</p> <p>The practice needs to consider how to provide access to patients who are not able to physically attend the practice. In many situations, a GP will be required, but in other situations, it may be appropriate for other health professionals, such as nurses or Aboriginal health workers/practitioners, to attend home visits under the supervision of a suitably qualified doctor, or make the home visit themselves in their role as a member of a team led by a GP.</p> <p>Visits may also be performed on behalf of the practice (for example by services that provide care outside normal opening hours). When this occurs, there must be a direct and continuing relationship between the practice's GPs and the practitioners who perform the home or other visits on their behalf. This includes arrangements to exchange clinical details about the patient's care and any concerns the practice may have about the safety of a visiting practitioner.</p> <p>Patients may be visited at home or in another setting, instead of coming into the practice, when:</p> <ul style="list-style-type: none"> • the patient is confined due to illness or disability • urgent treatment can be given more quickly by visiting the patient at home • the risk of infection is minimised if the patient is seen at home or in another setting. <p>To determine the circumstances under which a home or other visit is offered, the practice should have policies that specify:</p> <ul style="list-style-type: none"> • factors that make home and other visits safe and reasonable • geographical limits for home and other visits • personal circumstances and health concerns that necessitate a home visit • possible alternative arrangements if a home or other visit is not available. <p>GPs and other members of the practice team need to know the conditions under which a home or other visit is deemed appropriate according to the practice's policy.</p> <hr/> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Show patient records with entries of home and other visits practitioners have made and the time they occurred. • Have a signed agreement with each service that provides home and other visits on behalf of the practice. • Demonstrate that patients are advised of how they can access care when home visits are not considered safe or reasonable.

Criterion 5.2 – Accessible clinical advice

Indicators

- A. Our enrolled patients have access to clinical advice by telephone or electronic communication.

Meeting this Criterion

► A	<p>Explanation</p> <p>It is important that the practice has a process for patients to receive clinical advice by telephone or electronic communication.</p> <p>Patients need to be able to seek and receive interactive clinical advice (ie questions are answered by a person, rather than by a recorded message) by telephone or secure electronic communication (eg electronic message, website, video consultation) as part of the Medical Home model. 'Clinical advice' means a response to a patient inquiry about symptoms, their health status, or an acute or chronic condition.</p> <p>Qualified clinical staff should provide the clinical advice to patients, but it may be communicated by a member of the care team. Practitioners should return calls and respond to secure electronic messages in the period defined by the practice to meet the clinical needs of the patient population. The practice may have different processes for when it is open and when it is closed.</p> <p>When a member of the practice team provides information (such as the results of investigations) to a patient by telephone, they must make sure that the recipient of the information is correctly identified to maintain patient confidentiality. To do this, they should obtain three approved patient identifiers (items of information that are accepted for use to identify a patient), which include the patient's:</p> <ul style="list-style-type: none"> • family and given names • date of birth • gender (as identified by the patient) • address • patient record number where it exists • Individual Healthcare Identifier. <p>If you choose to communicate with patients using electronic means, such as email, secure messaging or SMS, you need to consider patient confidentiality and privacy in accordance with Australian Privacy Principles, which include:</p> <ul style="list-style-type: none"> • informing patients that there are risks associated with this method of communication and that their privacy and confidentiality may be compromised when communicating by electronic means, particularly as email is not usually encrypted • clearly stipulating what content can and cannot be sent using electronic communication. For example, you may decide that sensitive information such as HIV status or pregnancy results can only be communicated via telephone or face-to-face • obtaining required consent from the patient before the practice communicates health information to the patient electronically. It is important to note that consent is implied if the patient initiates electronic communication with the practice • verifying that the information will be sent to the correct email address or phone number before any information is sent. <p>The RACGP has developed a matrix to determine the level of security required in order to use email in general practice for communication. That matrix can be found at: www.racgp.org.au/your-Medical-Home/ehealth/protecting-information/email</p>
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Demonstrating how you meet this Indicator

The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.

Items in **red** are mandatory.

Items in **black** are optional.

- Implement a method for identifying patients over the phone that ensures that information is being provided to the right person.
- Provide clinical advice by telephone and electronic communication to patients both during and outside your opening hours.
- Keep a policy, procedure, or flow chart showing how to manage messages from patients.
- In the patient record, document when clinical staff have contacted the patient.
- Maintain a paper or electronic (eg email, SMS, voicemail) messaging system.
- Document what information and advice can and cannot be given to patients over the phone or electronically.
- Ensure that reception staff know which messages need to be transferred to clinical staff.
- Have an appointment system that includes time for the clinical team to return messages to patients.
- Have an automatic response that provides the practice's telephone number when emails are received when the practice cannot respond to them.
- Advise patients of the practice's policy for checking, responding to, and sending emails.

Criterion 5.3 – Medical Home accessibility

Indicators

- ▶ A. Our patients with disability or special needs can access our services.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>Ensure that all patients, including those with disability or other special needs, can easily and safely access the practice's premises and services. This can be achieved by:</p> <ul style="list-style-type: none"> • providing pathways, hallways, consultation areas and toilets that are wheelchair-friendly • having a wheelchair to assist patients while they are at the practice • installing appropriate ramps and railings • using pictures on signs and other sources of information to help patients who have an intellectual disability or vision impairment, or are not fluent in English. <p>Practices can improve the non-physical access to healthcare for patients with disabilities or special needs by:</p> <ul style="list-style-type: none"> • using existing and emerging technologies • providing patients access to telehealth or video conferencing consultations • making home visits where appropriate. <p>Where possible, patients with disability need to be able to park their vehicles within a reasonable distance of the practice's premises. For example, parking bays close to the front door that are large enough to accommodate the loading and unloading of wheelchairs and are specifically marked for the use of patients who have a disability parking entitlement.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Ensure that patients with disability or special needs can access the practice's services. • Provide disability parking. • Provide a transport service to help patients who are unable to get to the practice. • Provide home visits for patients who are unable to leave their place of residence. • Use signs with pictures to help patients who have an intellectual disability or a visual impairment, or are not fluent in English.

Standard 6: Safe, high quality care

Safe, high quality care, provided by GPs and general practice systems that aim for continuous quality improvement.

Criterion 6.1 – Clinical improvement

Indicators

- A. Our practice undertakes activities aimed at improving clinical practice.
- B. The care team has structured communication processes focused on individual patient care.

Meeting this Criterion

A	<p>Explanation</p> <p>To achieve ongoing improvement of clinical care, the practice may consider conducting a clinical audit. A clinical audit is a planned medical education activity designed to help practitioners systematically review aspects of their own clinical performance against defined best practice guidelines. A clinical audit has two main components:</p> <ul style="list-style-type: none"> • an evaluation of the care that an individual practitioner provides • a quality improvement process. <p>Research indicates that ‘audit and feedback is widely used as a strategy to improve professional practice, either on its own or as a component of multifaceted quality improvement interventions’⁷ and that ‘audit and feedback generally leads to small but potentially important improvements in professional practice’.⁷</p> <p>The team may also choose to complete a plan, do, study, act (PDSA) cycle to implement quality improvement. PDSA cycles encourage the individual practitioner or the care team to implement a planned improvement by breaking it down into small manageable stages, and testing each small change to make sure that improvement is being made and that no effort is wasted before moving to the next stage. It emphasises starting on a small scale and reflecting and building on learning that occurs during each stage. It can be used to quickly and easily test suggested improvements, based on existing ideas and research, or to implement practical ideas that have been successful elsewhere.</p> <p>It is a cyclical model because small changes can be made, the process can be refined, and the cycle repeated multiple times until the planned-for outcome is achieved.</p> <p>A PDSA cycle can be undertaken by an individual practitioner, a group of health professionals, and/or a multi-disciplinary team. For example, an individual practitioner can complete a PDSA cycle to improve their individual clinical knowledge and skills.</p> <p>Further information on clinical audits and PDSA cycles is available in the RACGP’s QI&CPD 2014–16 triennium handbook at www.racgp.org.au/download/Documents/QICPD/QICPD-Handbook-updated-April-2014.pdf</p> <p>To improve the targeting and use of prevention activities (eg smoking cessation, weight management), the practice team may wish to collect data from other sources, such as:</p> <ul style="list-style-type: none"> • clinical information systems or paper-based systems about, for example, smoking status • the diabetes register • private pathology providers that provide, for example, diabetes screening and cervical screening.
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Document activities aimed at improving clinical practice. • Maintain a quality improvement plan based on the activities to be completed by the practice team. • Engage with PHNs to undertake clinical audits.

▶ B	<p>Explanation</p> <p>Good communication between members of the care team in and outside the practice can be achieved with face-to-face meetings or other communication tools such as message systems. A structured communication process may include regular email exchanges, tasks or messages about a patient documented in the patient record. Care team meetings may be informal daily meetings or a review of daily schedules, with follow-up tasks.</p> <p>Having clinical guidelines available and having systems to facilitate discussions about patient care helps to identify and address clinical issues and deliver consistent and high-quality care.</p> <hr/> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Show that care team members use a structured communication process to discuss patient care. • Have a documented process for structured communication between the care team members, which states the frequency of communication. • Keep a record of care team meetings. • Ensure that care team members can access up-to-date and accurate clinical guidelines. • Have samples of meeting summaries, checklists, appointment notes or chart notes as evidence that the practice team follows appropriate processes. • Create and document a buddy system. • Use the practice's intranet or email to have discussions.
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Criterion 6.2 – Practice improvement

Indicators

- A. Our practice undertakes activities to improve our operations.
- B. Our practice has a structured communication process focused on operations.
- C. Our practice involves the care team in quality improvement activities, and seeks feedback from them about the success of these activities.

Meeting this Criterion

A	<p>Explanation</p> <p>One way of undertaking practice improvement activities is to complete a PDSA cycle. Further information on clinical audits and PDSA cycles is available in the RACGP's QI&CPD 2014–16 triennium handbook at www.racgp.org.au/download/Documents/QICPD/QICPD-Handbook-updated-April-2014.pdf</p> <p>PDSA cycles may occur at different times and new actions may be planned because of previous cycles. Alternatively, new skills may be learned, barriers to change overcome and new areas targeted for improvement. Testing small changes sequentially means design problems might be detected and amended earlier rather than later. Similarly, performance tends to fall away with time. Repeated measurement of both process and outcomes helps to identify current performance and any areas of concern.⁸</p> <p>When reviewing your practice's progress in making improvements:</p> <ul style="list-style-type: none"> • determine whether your goals have been achieved • decide if the goals were realistic • evaluate if activities designed to improve the practice have led to the desired degree of change • document what has helped or hindered the change • identify any further strategies or measures needed to bring about the desired changes. <p>Conducting annual quality improvement activities is considered good practice.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • At least annually, document activities aimed at improving operations. • Demonstrate quality improvements made to the practice or its systems in response to feedback, complaints or audits. • Form a quality improvement team made up of members of the clinical and administrative staff. • Include quality improvement as a standing agenda item at team meetings.

B	<p>Explanation</p> <p>Regular, scheduled team meetings that include clinical staff and administrative staff are a good way of discovering and resolving issues. The purpose of these meetings is to discuss general operations and staff functions to identify, for example, what is working well and what may need to be improved.</p> <p>Meetings can include discussions about staff roles and responsibilities, performance measurement data and related quality improvement efforts, team member training, and areas for improvement.</p> <p>Although the frequency of these meetings can vary (eg monthly, bimonthly, quarterly), they should be part of the practice team's routine operations.</p> <p>If patients will be affected by changes, it is a good idea to inform them at the earliest opportunity.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Document meetings where quality improvement is discussed. • Have a documented process for team members to escalate issues. • Ensure team members know how they can provide input. • Inform patients of any changes that will affect them. • During recruitment interviews and employee inductions, inform team members that they are encouraged to provide input into the practice's operations.
C	<p>Explanation</p> <p>Quality improvement can relate to many areas of a practice, so the collaborative effort of the entire team is necessary to achieve improvements in quality and safety of patient care. The practice could improve engagement by establishing a quality improvement group made up of members from all parts of the team, such as doctors, nurses, and administrative staff.</p> <p>Having all members of the team actively participating in quality improvement gives them an opportunity to come together to share information and consider how the practice can be improved.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Keep a record of meetings where quality improvement activities are discussed with the practice team. • Develop a quality improvement team made up of members of clinical and administrative staff. • Set aside time during each team meeting to discuss quality improvement systems with the practice team. • Have notice boards or suggestion boxes the team can use to contribute their ideas. • Conduct short surveys for the team to complete as part of a quality improvement plan.

Criterion 6.3 – Patient experience

Indicators

- ▶ A. Our practice seeks feedback from patients, carers, and other relevant parties.
 - B. Our practice seeks patient feedback from other practitioners in the care team who are outside the practice.
- ▶ C. Our practice analyses and responds to feedback and considers feedback to identify potential improvements.
 - D. Our practice involves patients, carers, and other relevant parties in quality improvement activities.

Meeting this Criterion

▶ A	<p>Explanation</p> <p>Regular and rigorous collection of feedback from patients, carers, and other relevant parties is considered good practise.</p> <p>Your practice can collect feedback using any method that meets the requirements of the RACGP <i>Patient feedback guide</i>. When deciding how you want to collect feedback from your patients, consider:</p> <ul style="list-style-type: none"> • the kind of information you want (eg broad or specific, general or in-depth) • the amount of time you have to conduct and analyse patient feedback • the demographics of your patients (eg education level languages spoken at home). <p><i>Collecting feedback all at once</i></p> <p>You could choose to use a formal method to collect feedback all at once from patients about their experience of accessing healthcare at your practice.</p> <p>If you choose a formal method, ideally this will be undertaken at least once every three years. You can use any of the following methods to collect formal feedback:</p> <ul style="list-style-type: none"> • a questionnaire developed by a commercial company • the RACGP's questionnaire • a practice-specific method that the practice chooses (eg focus groups, interviews) that meets the requirements of the RACGP's <i>Patient feedback guide</i>. <p>The RACGP's <i>Patient feedback guide</i> provides more detail on how to formally collect feedback from your patients.</p> <p><i>Collecting feedback on an ongoing basis</i></p> <p>You could choose to seek feedback from patients on an ongoing basis over a three-year period instead of conducting one formal method.</p> <p>For example, you could:</p> <ul style="list-style-type: none"> • conduct short questionnaires focusing on specific areas of interest (eg a new service, a change to the waiting area) that patients complete at the practice (eg on paper, on electronic tablets) or at home (using a link to the website or online using a questionnaire tool) • send an SMS to patients asking for their thoughts about a specific issue (making sure that you consider the practice's privacy policy and avoid breaches of privacy and anti-spam legislation) • hold patient forums and information days. <p>If you choose to collect feedback on an ongoing basis, you need to ensure that you still meet the requirements of the RACGP's <i>Patient feedback guide</i>.</p> <p>The RACGP's <i>Patient feedback guide</i> provides more detail on how to collect feedback from your patients on an ongoing basis.</p> <p>Practices can also encourage patients to raise any concerns with the team directly.</p>
	<p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator. Items in red are mandatory. Items in black are optional.</p> <ul style="list-style-type: none"> • Provide evidence of feedback sought from patients. • Provide evidence that you address and discuss issues raised by patients and have made improvements in response to their feedback. • Incorporate quality improvements into relevant policies and procedures.

B	<p>Explanation</p> <p>It is important that members of the care team outside the practice also collect patient feedback.</p> <p>The practice should enquire if other members of the care team are seeking feedback from patients. If so, this information should be sent to a central location in a standard format that can be reviewed easily.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.</p> <p>Items in red are mandatory.</p> <p>Items in black are optional.</p> <ul style="list-style-type: none"> • Provide evidence of patient feedback received from members of the care team outside the practice.
► C	<p>Explanation</p> <p>This Indicator involves analysing and responding to feedback received from patients, carers, and other relevant parties, and using the feedback to make quality improvements.</p> <p>Not every suggestion made by patients will be practical, feasible, or desirable. It is up to your practice to decide what feedback will be used, and to prioritise activities based on the feedback.</p> <p>After collecting and analysing patient feedback, examine the results, identify key issues, and decide on a plan of action to achieve quality improvement.</p> <p>Because patients value knowing that their feedback has been respectfully considered and implemented where possible, it is a good idea to inform patients of the quality improvement activities implemented because of patient feedback received. If you received a lot of feedback about something that is not feasible (such as putting a coffee maker in the waiting room), you could explain to patients why this suggestion is not viable.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.</p> <p>Items in red are mandatory.</p> <p>Items in black are optional.</p> <ul style="list-style-type: none"> • Provide evidence that feedback from patients, carers, and other relevant parties has been analysed and considered for quality improvement. • Inform patients about how you have responded to patient feedback and complaints: <ul style="list-style-type: none"> – on the practice website and notice board – by providing information to the local media, where appropriate – by including relevant information in a newsletter or letters sent directly to patients. • Keep a record of team meetings dedicated to analysing and responding to patient feedback. • Send a summary of the feedback to each member of the care team, and ask them what quality improvement activities they think could be implemented.
D	<p>Explanation</p> <p>Practices should consider developing a process for involving patients, carers, and other relevant parties in quality improvement efforts. The process could specify how patients and others are selected, their role on the quality improvement team, and the frequency of team meetings.</p> <p>Demonstrating how you meet this Indicator</p> <p>The following list contains ways your practice can demonstrate how you meet the requirements of this Indicator.</p> <p>Items in red are mandatory.</p> <p>Items in black are optional.</p> <ul style="list-style-type: none"> • Document the process for involving patients, carers, and other relevant parties in quality improvement activities. • Keep a record of meetings with patients, carers, and other relevant parties where quality improvement activities were discussed.

Glossary

Aboriginal health worker/practitioner	<p>A member of the indigenous health workforce. Roles include:</p> <ul style="list-style-type: none"> • providing clinical functions • liaison and cultural brokerage • health promotion • environmental health • community care • administration • management and control • policy development • program planning. <p>They are often an Indigenous Australian's first point of contact with the health workforce, particularly in remote parts of the country.</p>
Administrative staff	Staff employed by the Medical Home who provide clerical or administrative services and who do not perform any clinical tasks with patients.
After-hours service	A service that provides care outside the normal opening hours of a general practice, whether or not that service deputises for other general practices, and whether or not the care is provided physically in or outside of the clinic.
Allied health professional	A health professional who collaborates with doctors and nurses to provide optimal healthcare for patients (eg physiotherapists, dietitians, podiatrists).
Appointment system	The system that a practice uses to assign consultations to patients and practitioners.
Care outside normal opening hours	Clinical care that is provided to the practice's patients when the practice is normally closed. (Different practices can have different opening and closing hours.)
Carer	Someone who provides care and support to a family member or friend who is frail, or has a disability, mental illness, chronic condition, or terminal illness.
Care team	A multidisciplinary team of practitioners who are responsible for the care of patients enrolled in the Medical Home. The care team are physically located both within and external to the Medical Home.
Clinical decision-making tools	Electronic or paper-based supports to assist clinicians and their patients make decisions. They commonly assist the patient (and clinician) to go through several necessary steps: listing the options available; quantifying the benefits and harms of each; and then ensuring that the patient's preferences are articulated, and then incorporated, into the final decision. ⁹
Clinical information system	A computer-based system designed for the collection, storage, retrieval, and reporting of clinical and patient information to assist in healthcare delivery processes.
Clinical significance	A way of referring to an assessment of the probability that a patient will be harmed if they do not receive further medical advice, treatment or other diagnostics, and the likely seriousness of the harm.
Clinical team	Staff employed by the Medical Home who have health qualifications and provide clinical care for patients.
Complaint	Any verbal or written expression of dissatisfaction or concern with an aspect of the general practice. A complaint may be made using, for example, a complaints process, consumer surveys, or focus groups.

Cooperative	A group of general practices that have an arrangement to work together to provide care to patients outside the normal opening hours of their practices.
Cultural background	Details of a patient's ethnic or cultural heritage that the practice has collected and recorded.
Cultural safety	<p>The condition created when people respect, and are mindful of, a person's culture and beliefs, and do not discriminate against that person because of their culture or beliefs.</p> <p>Health service organisations have a responsibility to 'develop and sustain healthcare services that are free from discrimination and delivered in a manner that shows respect for patients and consumers' (quoted from <i>Roles in Realising the Australian Charter of Healthcare Rights</i> released by the Australian Health Ministers in 2008).</p>
Disability	<p>An umbrella term for any one, or combination, of the following:</p> <ul style="list-style-type: none"> • impairments resulting in problems in body function or structure • activity limitations resulting in difficulties in executing activities • participation restrictions resulting in problems an individual may experience in involvement in life situations.
Discrimination	Different treatment or consideration of a patient based on particular characteristics (such as gender, age, ethnicity, religion). Positive discrimination enhances the care given to the patient, and negative discrimination potentially reduces, or does reduce, the quality of the patient's care.
Documented standardised clinical terminology	The structured vocabulary that clinical practices use to accurately and consistently describe the care and treatment of patients.
Electronic communication	The transfer of information (including but not limited to patient health information) within or outside the practice using email, internet communications, SMS, or facsimiles.
Emergency contact	The person who a patient has nominated to be contacted in an emergency.
Encryption	The process of converting plain text characters into meaningless data to protect the contents of the data and guarantee its authenticity.
Enrolled patient	A patient who has enrolled with the practice by establishing a formal agreement with the practice to coordinate, manage and support their care. This agreement would establish an ongoing partnership between the patient and the Medical Home, each with responsibilities for shared goals and outcomes according to an agreed care plan. ¹
Ethical dilemma	The need to choose between two courses of action, both of which will result in an ethical principle being compromised.
Ethics (or code of behaviour)	The principles adopted by an organisation to ensure that all its decisions and actions conform to normal and professional principles of conduct.
Follow up	<p>Activities that are the logical and responsible steps to take after taking earlier related actions. For example:</p> <ul style="list-style-type: none"> • making a phone call to find out the status of tests and results that are expected but not yet been received • contacting a patient to discuss a report, test, or results.
Gender	A classification based on socially constructed differences between men and women that result in roles and expectations being assigned according to whether someone identifies (or is identified) as male or female. (The word 'sex' refers to the biological and physiological characteristics that define men and women.)

General practitioner	A registered medical practitioner who: <ul style="list-style-type: none"> • is qualified and competent to provide general practice anywhere in Australia • has the skills and experience to provide patient-centred, continuing, comprehensive, coordinated primary care to individuals, families and communities • maintains professional competence in general practice.
Health information	A subset of a patient's personal information that is collected in connection with the provision of a health service. It includes information or opinions about the health or disability of an individual, and a patient's wishes about future healthcare and health services.
Health outcome	The health status of an individual, a group of people or a population that is wholly or partially attributable to an action, agent, or circumstance performed, provided or controlled by a general practice or other health professionals, such as nurses and specialists.
Health promotion	The process of enabling people to increase their control over, and improve their health. More than just influencing an individual's behaviour, it includes a wide range of social and environmental interventions.
Health summary	Documentation usually included in a patient's health record that provides an overview of all components of the patient's healthcare. For example, current medications, relevant past health history, relevant family history, allergies, and adverse drug reactions.
High-risk results	Clinical test results that are seriously abnormal and life-threatening and need to be communicated in an appropriately timely manner.
Home visit	A general practice consultation conducted in the patient's (or someone else's) home.
Individual Healthcare Identifier	The unique 16-digit number allocated by the Department of Human Services to an eligible Australian patient who seeks healthcare.
Information security	The protection of the confidentiality, integrity, and availability of information.
Informed consent	The written or verbal consent that a patient gives to the proposed investigation, proposed treatment, or invitation to participate in research, when they understand the relevant purpose, importance, benefits, and risks. For consent to be valid, a number of criteria need to be satisfied, including: <ul style="list-style-type: none"> • the patient has received and understood sufficient and appropriate information and is aware of the material risks • the patient has the mental and legal competence to give consent.
Informed refusal	A patient's refusal of proposed or recommended medical treatment when they understand all relevant information, including the implications of refusing the treatment.
Interpreter service	A service that provides trained language interpretation or translation, either face-to-face or by telephone.
Lifestyle risk factors	Habits or behaviours that people choose to engage in that, if changed, can directly affect some medical risk factors by reducing the likelihood of developing disease.
Medical deputising service	A service that arranges for, or facilitates, the provision of medical services to a patient by a medical practitioner (deputising doctor) during the absence of, and at the request of, the patient's GP (principal doctor).
Medical Home	An approach to providing high-quality patient care whereby each patient has a stable and ongoing relationship with a general practice that provides continuous and comprehensive care to people at all life stages.

Medication	Substances used to treat an illness or medical condition. They can be a prescription medicine, or over-the-counter medication, and can include complementary medicines.
Medicine	A drug or other preparation for the treatment or prevention of disease.
Non-drug therapy	Any intervention intended to improve health or wellbeing that does not involve the use of any drug or medicine. This broad definition encompasses well-established interventions such as physiotherapy and dietetics as well as 'complementary and alternative therapies' (often referred to as CAM). It includes bibliotherapy and other self-directed psychological therapies, various exercise regimes, and participation in self-help groups.
Nurse	A registered nurse who can demonstrate competence in the provision of nursing care. A registered nurse practices independently and interdependently, and has accountability and responsibility for their own actions and the delegation of care to enrolled nurses and other healthcare workers.
Open disclosure	The way in which clinicians are encouraged to communicate with and support patients, their family and carers who have experienced harm while receiving, or as a result of receiving, healthcare.
Other visit	A general practice consultation conducted somewhere that is not the general practice or the patient's home (eg a residential aged care facility, a workplace).
Outside normal opening hours	The hours other than the practice's normal opening hours.
Over-the-counter medicine	Medicines that people can purchase from retailers (such as pharmacies, supermarkets, and health food stores) for self-treatment.
Patient	A person who is enrolled with and receiving healthcare from the Medical Home. In relevant circumstances, the term also refers to a carer.
Patient health information	A patient's name, address, account details, Medicare number and any information (including opinions) about the patient's health.
Patient record	Information, in paper or electronic form, held about a patient, which may include contact and demographic information, medical history, notes on treatment, observations, correspondence, investigations, test results, photographs, prescription records, medication charts, insurance information, legal information and reports, and work health and safety reports.
Policy and procedures manual	A document containing the practice's policies and procedures.
Practice information sheet	A document that contains information that patients need to know about the services the practice provides, and how to access those services. It must not be hand-written.
Practitioner	A member of the care team who has health qualifications that qualify them to perform clinical functions.
Privacy of health information	The protection of personal and health information to prevent unauthorised access, use and dissemination.
Qualified	Holding the educational or other qualifications required to perform a specific activity (eg administer first aid) or hold a specific role (eg GP, registered nurse).
Quality improvement	One or more activities that a practice undertakes to monitor, evaluate, or improve the quality of healthcare it delivers.
QI&CPD (Quality improvement and continuing professional development)	Educational activities endorsed by the RACGP that lead to improved quality of clinical care.
Recall	The process of requesting a patient to attend a consultation to receive further medical advice on matters of clinical significance.

Referral	The process of sending or directing a patient to another practitioner.
Relevant family history	Information about a patient's family history that the practitioner considers important in order to provide appropriate clinical care to the patient.
Relevant social history	Information about a patient's social history (including employment, accommodation, family structure) that the practitioner considers important in order to provide appropriate clinical care to the patient.
Safe and reasonable	A desired description of the outcome of a clinical care decision made by a practice that was based on relevant factors (eg the practice's location and patient population) and an understanding of what their peers (or practices in the same area) would agree was safe and reasonable.
Secure message delivery	A system designed by the Australian government for the electronic exchange of sensitive and confidential clinical and patient information such as referrals, reports, pathology and radiology requests and results, and discharge summaries.
Shared electronic patient record system	A collection of patient data that can include demographic and billing information, family history, medical history, medicines, allergies and adverse reactions, immunisations, pathology and diagnostic imaging results, and specific patient statistics such as weight and height, that can be accessed by all providers involved in the patient's care.
Sociable hours	The after-hours period between 6.00–11.00 pm on weeknights.
Social media	Online social networks used to disseminate information through online interaction.
Standard clinical practice	A standard of practice that might reasonably be expected by the public or professional peers.
Technology-based consultations	Consultations that use any form of technology to communicate (such as video-conferencing, internet and telephone), instead of face-to-face interactions.
Telephone triage	A method of determining, over the telephone, the nature and urgency of problems and providing directions to achieve the required level of care.
Timely	Within an appropriate period for the given situation, as might reasonably be expected by professional peers.
Triage	Patient prioritisation based on where resources can be best used or are most needed.
Unsociable hours	The following after-hours periods: <ul style="list-style-type: none"> • weekdays – 11.00 pm to 8.00 am • Saturdays – before 8.00 am and after 12.00 pm • Sundays and public holidays – any time.
Urgent	Requiring immediate action or attention.

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