



NURSE LED CLINICS TOOLKIT

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Version dated: SEPTEMBER 2019

CONTENTS

PAGE

4 Introduction

- 4 HNECC PHN Nurse Led Clinic Strategy
- 4 At a glance: Nurse Led Clinics
- 6 Four essentials to improving Nurse Led Clinics in Primary Care

7 Developing a systematic approach

- 7 Data cleansing
- 7 Work flow
- 8 Implementing robust recall and reminder systems
- 8 How can PEN CS support patient-based outcomes in General Practice?

10 What is Quality Improvement?

- 10 Standards for General Practice - 5th Edition
- 10 The 'Thinking' part
- 12 The 'Doing' part

14 Readiness Tool

18 Change ideas to consider

19 Resources for undertaking Quality Improvement

- 19 Quality Improvement Goal Setting
- 20 Quality Improvement Action Worksheet
- 21 Measuring Success

INTRODUCTION

HNECC PHN Nurse Led Clinic Strategy

Hunter New England and Central Coast (HNECC) PHN is a non-profit organisation that is funded by the Commonwealth Government and provides ongoing support to all practices and health professionals within the primary care setting.

HNECC PHN is committed to working with and through general practice to enable delivery of best practice outcomes and experiences for patient populations through continuous quality improvement and data driven processes. Nurse Led Clinics are an effective way to involve patients in their own health care by providing an integrated and patient-centred approach to care.

At a glance: Nurse Led Clinics

With increasing demands on Primary Health Care services, Nurse Led Clinics are an innovative approach to delivering timely, effective, holistic person-centred care.

Nurse clinics offer an alternative model of care delivery where the nurse is the primary provider of care for the patient. The nursing services provided are holistic and patient-centred, with accountability and responsibility for patient care and professional practice remaining with the nurse. In the general practice setting, nurse clinic models support a team-based approach to care delivery, and involve the general practitioner and other members of the practice team (APNA, 2019a).

Generally, nurse led clinics address an area of need relevant to the requirements of the specific population. Examples include:

• Women's Health	• Chronic Disease (Asthma, Cardiovascular Disease etc)	• Sexual Health or Family Planning
• Immunisations	• Lifestyle Modification	• Continence
• Men's Health	• Mental Health	• Child Health
• Diabetes	• Wound Management	• Aged Care

The benefits of Nurse Led Clinics include:

- Improved access to comprehensive, person-centred care
- Opportunity for nurses to increase scope of practice and professional autonomy
- Increased flexibility in workflow and patient management
- Opportunity to spend more time with patients and establish rapport
- Improved care coordination and continuity of care
- Opportunity to engage patients in taking a more active role in their own healthcare
- Improved outcomes for patients

The aim of this toolkit is not to provide step by step instructions on setting up a nurse clinic as each clinic will be structured and run differently. Rather this toolkit is to assist practices in establishing their readiness for change and implementing a systematic approach to quality improvement to lay the foundations for establishing a Nurse Led Clinic.

This toolkit will link in with the [APNA Building Blocks](#) for Nurse Led Clinics which provide more detailed information on the core components of setting up a clinic.

The initial step in establishing a Nurse Led Clinic is to understand the specific need for your service.

Your clinic may already have an idea for a nurse led clinic in mind based on existing gaps in services, or you may need to analyse your practice data to identify potential opportunities.

You can use PenCAT recipes to search for specific opportunities or the Primary Care Improvement Team can provide you with your practice Dashboard Report.

Articulating patient need and community benefit makes it easier to respond to issues and make critical decisions throughout the planning process (APNA, 2019b).

The next step is to consider the model of care that will form the foundations of the clinic and how it operates.

A “model of care” defines the way health services are delivered and should be based on patient or community need. A model of care needs to be evidence based, with a patient centred approach to care delivery, focusing on delivering the right care to the right person, at the right place and time (APNA, 2019b)

Building Blocks for Nurse Led Clinics

A Clear Plan

- Identifying opportunities
- Creating the plan
- Aims and goals
- Clinic models

Location and Facilities

- Physical space
- Clinic operating times
- Equipment

Best Practice

- Evidence-based care
- Clinical guidelines
- Quality improvement approach

Supporting Systems and Process

- Appointment systems
- Referrals
- Patient registers
- Forms, templates and policies
- Data management

Funding

- Types of funding and how they apply to the clinics
- Sustainability

Staffing and Human Resources

- Roles and responsibilities
- Human Resource policies and planning
- Professional development
- Working as a team
- Formulating relationships

Patient Engagement

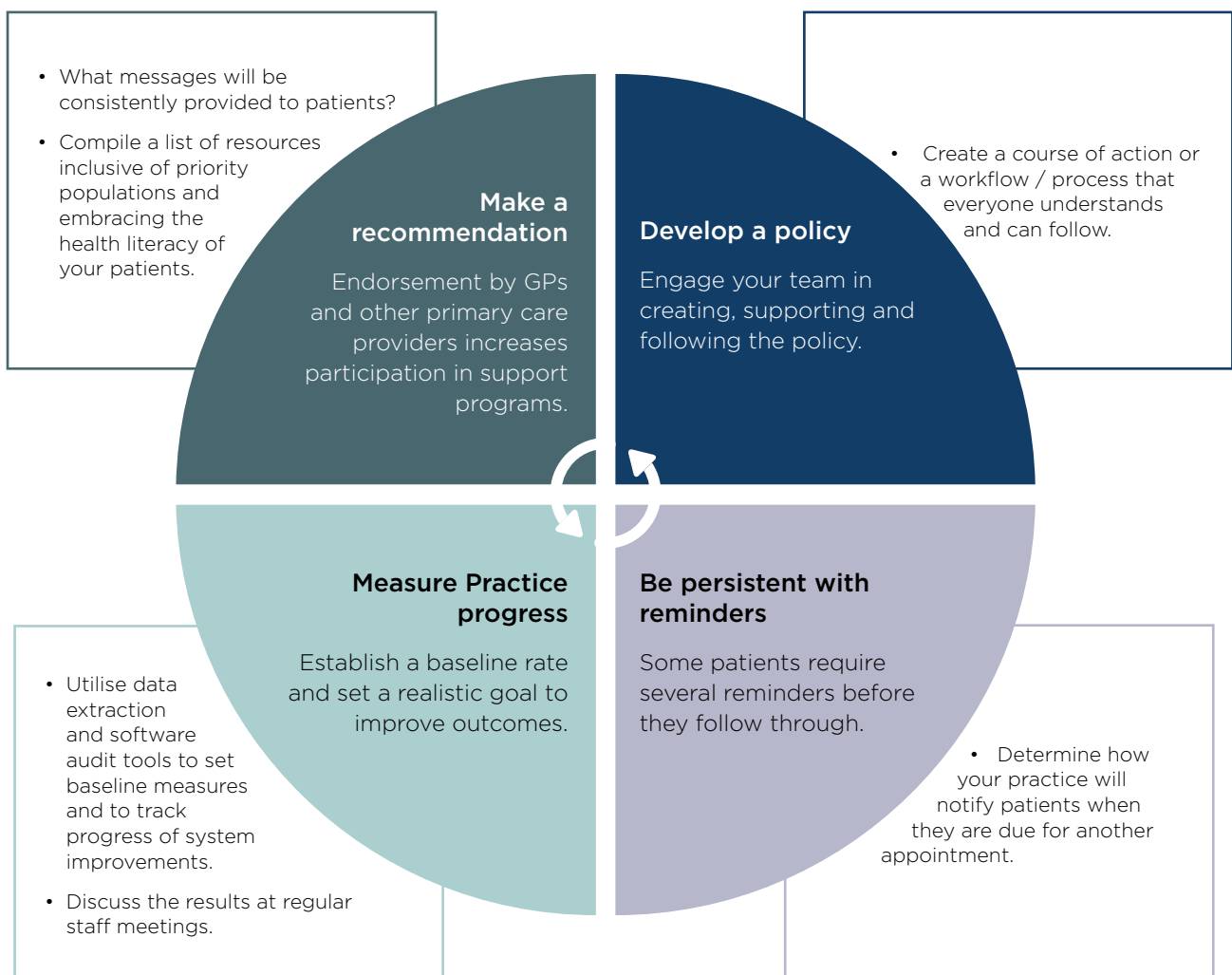
- Patient pathways
- Creating appointments
- Reminders and recalls
- Promoting the clinic

Evaluation and Improvement

- Health outcomes
- Clinic efficiency
- Evaluating the patient experience

Four essentials to improving success of Nurse Led Clinics in Primary Care

1. Implement practice changes.
2. Take a person-centred approach.
3. Involve staff and put office systems in place.
4. Follow a continuous improvement model to develop and test the changes.



DEVELOPING A SYSTEMATIC APPROACH

Data cleansing

The information available in clinical software is invaluable when developing streamlined practice systems and providing quality patient care. For practice data to be useful, information within your clinical database must be accurate and up to date.

Ensuring electronic results are received correctly is key to providing effective and efficient patient care.

High quality information means better patient care and better safety.



HELPFUL TIPS

- Regularly mark patients as 'inactive'
- Merge duplicate patient records
- Ensure pathology results are received in the correct format
- Develop and agree on processes to ensure data quality is maintained
- Clean up reminder lists: Ask your Primary Care Improvement Officer for instructions on 'Bulk Reminder Clean Up'
- Document processes clearly in your Policy and Procedure Manual
- Regularly discuss clinical coding in team meetings to develop clear standards and requirements for patient files
- Avoid free text.

Work flow

Workflow is defined as a series of steps, frequently performed by different staff members that accomplishes a task. Workflows represent how work gets done, not the protocols that have been established to do the work.

Workflow mapping is a way of making the invisible "visible" to a practice to improve processes to increase efficiency, reduce errors, and improve outcomes.

Workflow mapping is the process of documenting the specific steps and actions that take place in completing a task. Creating a workflow map allows the opportunity to see what is currently happening, identify opportunities for improvement or change, and design new, more effective processes. It is helpful to consider workflows associated with the following three processes:

1. Perceived process (what we think is happening)
2. Reality process (what the process actually is)
3. Ideal process (what the process could be).



HELPFUL TIPS

Important rule of mapping: the person who controls the process controls the pen. Meaning whomever carries out the process, maps the steps.

- Be realistic: map what is happening not what is desired
- Identify each step of the activity and person responsible
- Communicate: ensure all team members involved understand how the activity is executed.



HELPFUL LINKS & RESOURCES

Train IT Medical have sample workflows for:

[Correspondence Management](#)

[Inbox Management](#)

[Train IT Medical Practice Management resources](#)



Implementing robust recall and reminder systems

The RACGP Standards for General Practice view a **reminder** as an offer to provide patients with systematic preventative care. A **recall** is when it is paramount for a patient to attend the clinic, usually in the instance of an abnormal result. A recall is further defined as a system to make sure patients receive further medical advice on matters of clinical significance.

Clinical significance is determined by:

- the probability that the patient will be harmed if further medical advice is not obtained; and
- the likely seriousness of the harm.

It will be up to each practice to design a system which effectively differentiates between their general preventive reminders and their true recalls (RACGP, 2017).



HELPFUL TIPS

- Ensure there is a written policy which is communicated to the practice team which outlines a consistent and validated process for recording results, entering recalls and sending reminders
- Define roles and responsibilities for individual team members
- Review systems for managing overdue patient recall and reminders.



HELPFUL LINKS & RESOURCES

Speak to your Primary Care Improvement Officer to gain access to best practice resources:

[Medical Director: Recall, Reminders Action Fact Sheet](#)

[The Dos and Dont's of Patient SMS](#)

[AMA Recall Systems and Patient Consent](#)

It is recommended that GPs who are coordinating patient-centred care should not assume that clinically significant test results ordered by others have been adequately followed up.

Clear and agreed systems for receiving and following up on test results are needed to ensure safe and effective continuity of patient care. For further information regarding RACGP's position on non-GP initiated testing [click here](#).

How can PEN CS support patient-based outcomes in General Practice?

When leading change in a General Practice, you will require data to help guide your thinking, discussions and planning.

PEN CS's Clinical Audit Tool 4 (CAT4) is a user-friendly software tool that interrogates the data contained within GP clinical and management software. The extracted data can be then filtered to select a specific target group and viewed through a range of clinically relevant patient reports to support quality improvement.

PEN CS and your Practice

A significant number of General Practices across the HNECC PHN already use CAT4 to investigate and report against their patient data. Using CAT4 to extract relevant data provides practices a range of benefits including:

- Improving the quality of patient care by identify patients requiring periodic screening and ensuring the appropriate treatment or referral is delivered proactively
- Identifying patients “at risk” of developing certain diseases or conditions and offering preventative treatment.



HELPFUL TIPS

- Use current data by performing monthly data collection
- Ensure correct coding principles are implemented to ensure data can be extracted
- Upskill; participate in PEN CS and [TopBar webinars](#) and speak with your Primary Care Improvement Officer to assist in understanding your practice data.



HELPFUL LINKS & RESOURCES

PEN CS has developed ‘recipes’ which are simple step by step guides to extract meaningful data correctly.

Visit www.pencs.com.au to source recipes identifying patients eligible for Nurse Led Clinics.



WHAT IS QUALITY IMPROVEMENT?

The RACGP Standards for General Practice describes quality activity undertaken within a general practice where the primary purpose is to monitor, evaluate or improve the quality of health care delivered by the practice. The Standards recommend practices engage in quality improvement activities that review structures, systems and processes to aid the identification of required changes to increase the quality of healthcare delivery and safety of patients.

Quality improvement consists of systematic and continuous actions that lead to measurable improvement in health care services and the health status of targeted patient groups.

Engaging in quality improvement activities is an opportunity for the practices' GPs and other staff members to come together as a team to consider quality improvement. Quality improvement can relate to many areas of a practice and achieving improvements will require the collaborative effort of the practice team.

Standards for General Practice - 5th Edition

The RACGP 5th Edition Standards have been released with a new module specifically identified for Quality Improvement. Criterion QI 1.1 identifies four indicators that relate to Practice based activity around Quality Improvement and reference a team-based approach. The criterion recommends having at least one team member responsible for leading quality improvement in the practice, which establishes clear lines of accountability. Please refer to the guidelines.

Criterion QI 1.3 relates to improving clinical care, specifically practice use of relevant patient and practice data to improve clinical practice. Establishing and utilising robust reminder and recall systems could be a focus under this criterion.

The Quality Improvement process (the Model for Improvement) is divided into two manageable steps, the "thinking" and "doing" part.

This process allows ideas to be broken down into management sections which can be tested and reviewed to determine whether improvement has been achieved prior to implementing on a larger scale.

The 'Thinking' part

The thinking part consists of three fundamental questions that are essential for guiding improvement.

1. What are we trying to accomplish?

By answering this question, you will develop your aim for the activity.

Consider exactly what it is you are seeking to change.

- Define the problem. Success comes through preparation Understanding what the problem is and thinking about why there is a problem helps in developing your aim.
- Set realistic objectives which are specific, have a defined timeframe and are agreed (SMARTA). Use plain language and avoid jargon so that the meaning is clear to everyone.
- Include information that will help keep the team focused.

2. How will we know that change is an improvement?

By answering this question, you will develop measures for tracking your goal.

Without measuring, it is impossible to know whether the change you are testing is an improvement.

- Communicate to the team what you are measuring, how, when and who is responsible (see 'Measuring Success').
- Make the measurement as simple as possible.
- Only collect the data that is required.

3. What changes can we make that will result in an improvement?

By answering this question, you will develop ideas for change.

Encourage the whole team to contribute ideas. Be creative. Think outside the box.

- You know your General Practice and your patients best. Keep this in mind and use your knowledge and experiences to guide your ideas.
- Adapt from others.
- Think small and test. Think about testing a change with one GP or a select group of patients. This will assist in determining if the change had the desired effect and suitable for wider implementation.

FOR EXAMPLE - following the example from APNA of the Skip for Life Clinic (See Appendix A):

SKIP into Life is a person-centered clinic which aims to improve the health and wellbeing of people with enduring mental illness by preventing and managing chronic disease. It is part of the Worrigee Medical Centre, a bulk billing practice near Nowra, South Coast NSW, with a SWPE of 5030.

You may have an aim like this:

To improve the health and wellbeing of people with enduring mental illness by preventing and managing chronic disease.

Your response may be:

We will measure through CAT4:

- The number of eligible patients aged 18-65 with a mental health diagnosis our practice who also have a diagnosed chronic disease
- The number of patients who have a diagnosed mental illness who are at risk of developing chronic disease.

Your outcome may include:

- Use CAT4 to extract the data.
- Provide training to ensure both clinicians and non-clinicians have the necessary skills and confidence to discuss chronic disease and mental health issues
- Apply the building blocks to establish the clinic
- Develop a plan for patient flow
- Send invitation letters to eligible patients
- Develop a referral pathway for patients identified opportunistically.

The 'Doing' part

The doing part is made up of rapid, small Plan, Do, Study Act (PDSA) cycles to test and implement change in real work settings.

Not every change is an improvement, but by making small changes you can test the change on a small scale and learn about the risks and benefits before implementing change more widely. Several PDSA cycles may be required to achieve your improvement goal.

You will find through PDSA cycles some changes lead to improvements. If so, these improvements can be implemented on a wider scale. You may also find that some improvement ideas are not successful. Analyse why they didn't work and learn from this. By carrying out small tests in PDSA cycles, you have avoided implementing unsuccessful change on a wider scale.

Step One: Plan

A well-developed plan includes what, who, when, where and your predictions and what data is to be collected.

Make your plan as clear and as detailed as possible:

- What exactly will you do?
- Who will carry out the plan?
- When will it take place?
- Where will it take place?
- What do you predict will happen?
- What data/information will we collect to know whether there is an improvement?

Step Two: Do

Write down what happens when the plan is implemented (both negative and positive) and other observations.

Collect any data you identified in the plan phase.

Step Three: Study

Reflect on what happened.

Think about and summarise what you have learnt. Analyse the data collected and compare with your initial predictions. If there is a difference in the data and predictions, consider what happened and why.

Step Four: Act

Considering the results from your tests; will you implement the tested change or amend and test or try something else?

Write down the next idea you will test. Be sure to start planning the next cycle early to keep up the momentum of change.



FOR EXAMPLE - following the example from APNA of the Skip for Life Clinic

Idea	Use CAT4 to extract the number of eligible patients aged 16-85 with a mental health diagnosis who also have a diagnosed chronic disease.
Plan	<p>What: Use CAT4 to extract data</p> <p>Who: Practice Manager</p> <p>When: Wednesday 3 November 2019</p> <p>Where: General Practice</p> <p>Data to be collected: The number of eligible patients aged 18-65 with a mental health diagnosis in our practice who also have a diagnosed chronic disease.</p> <p>Prediction: approximately 45% Australians aged 16-85 will experience a high prevalence mental disorder, such as depression, anxiety or a substance use disorder in their lifetime with 1 in 5 Australians experiencing a mental disorder in the preceding 12 months (Australian Bureau of Statistics, 2019).</p> <p>Australian Bureau of Statistics figures show almost 12 per cent of Australians aged between 16 and 85 years – an estimated 1.9 million people – have both a mental disorder and a physical condition.</p>
Do	Practice Manager extracted data as planned using PenCS Recipe to ensure correct data was extracted.
Study	Percentage of patients with a mental health diagnosis and a chronic disease was as expected.
Act	Data presented to practice team to discuss management strategies that could be implemented within a nurse led clinic in the practice.

Use PENCS recipes to identify potential areas for a nurse led clinic:

<http://help.pencs.com.au/display/CR/CAT+RECIPES>



HELPFUL TIPS

- Practices need to engage in quality improvement activities to improve quality and safety for patients in areas such as practice structures, systems and clinical care
- Decisions on changes should be based on practice data (PEN CS and clinical database audits, near misses and patient and/or staff feedback)
- Achieving improvements requires the collaborative effort of the practice team and all members of the team should feel empowered to contribute
- Utilise the Readiness Tool to assist identify ideas and areas for improvement.
- No PDSA cycle is too small; keep it simple
- You may complete a series of PDSA cycles to achieve your goal. Results will be achieved through building on previous cycles
- Set aside protected time to complete the agreed upon tasks
- Document your PSDA cycles and present findings at team meetings
- Improvement is a team effort.

See Criterion C4.1 – [Health Promotion and Preventative Care RACGP 5th Standards](#)

READINESS TOOL

It is important to remember that there are many types of nurse led clinics, and each will run differently.

This Readiness Tool is based on APNA's building blocks for nurse led clinics. It is designed as a starting point to encourage clinicians in General Practice to generate ideas and strategies to develop and implement a plan for a Nurse Led Clinic. This may assist with the 'thinking part' of the quality improvement cycle.

In working through the Readiness Tool, start by identifying if the practice or clinicians are undertaking activity in the identified area, or the topic has been discussed as a team. In the action column identify any ideas you may like to consider changing.

Nurse Led Clinic Quality Improvement Readiness Tool

General Practice Name:	
Completed by:	
Staff involved in change process:	

AREA: A clear plan	Yes/No	Action/Comment (what, when, who)
1. There is an active focus on nurse led patient management. Eg. Discussed at practice meetings, nurses proactively involved in chronic disease management and health assessment, reminder/recall systems, nominated clinical champions.		
2. The practice undertakes health promotion activities that are relevant to a Nurse Led Clinic		
3. The aim and goals of the Nurse Led Clinic are articulated		
4. Discussed model of care for delivering service.		
5. Created a business case to demonstrate viability of clinic.		

AREA: Funding Nurse Clinics	Yes/No	Action/Comment (what, when, who)
1. Identified and discussed costs associated with running clinic with team.		
2. Developed a budget for establishing clinic and operational costs.		
3. Identified source/s of funding for clinic.		

AREA: Locations and Facilities	Yes/No	Action/Comment (what, when, who)
1. Identified clinic space and considered safety, privacy and accessibility issues.		
2. Identified equipment and resources required.		
3. Discussed clinic hours and appointment times.		
AREA: Best Practice Care	Yes/No	Action/Comment (what, when, who)
1. Applied evidence based principles and guidelines to own model of care.		
2. Use a quality improvement approach as the framework for planning and implementing clinic.		
3. Tested ideas using PDSA cycle.		
AREA: Patient Engagement	Yes/No	Action/Comment (what, when, who)
1. Defined patient eligibility criteria.		
2. Identified sources of recruitment (identified from data audit, referrals from other healthcare practitioners, self referral).		
3. Developed patient pathway including initial contact and eligibility assessment, initial assessment, care planning and coordination, information provision, clinical handover and referral.		
4. Discussed promotion of the clinic within networks and community.		



AREA: Staffing and HR	Yes/No	Action/Comment (what, when, who)
1. Established roles and responsibilities for clinical and support staff.		
2. Developed position descriptions for team member roles.		
3. Ensure relevant HR policies are in place.		
4. Considered governance and stakeholder management, relevant to the size of your clinic.		
5. Have staff identified relevant areas for increasing knowledge and skills and made a plan for Professional Development.		
6. The practice has considered the scope of practice and identified pathways for improving it.		
AREA: Supporting Systems and Processes	Yes/No	Action/Comment (what, when, who)
1. Regular data cleansing activities are undertaken to establish up to date lists (registers) of eligible patients for Nurse Led Clinics.		
2. Practice software is utilised for actions/prompts for the GP/Nurse to discuss eligibility for referral to a Nurse Led Clinic.		
3. Policies and procedures are in place for reminders and recalls		
4. The practice sends targeted reminders to patients (eg. letters, SMS, email or phone calls.		
5. Your practice routinely identifies Aboriginal and Torres Strait Islander patients		
6. Your practice routinely identifies CALD patients/ language spoken and utilises Telephone Interpreter Services where appropriate		
7. Your practice has the flexibility to allow for protected/structured clinic time.		

AREA FOR ACTION (Go to PDSA template in your toolkit or see suggested PDSA activities)

1.

2.



CHANGE IDEAS TO CONSIDER

These ideas are suggestions only, with the concept adaptable across the development of Nurse Led Clinics.

Idea: Encourage person centred care by encouraging patients to discuss eligibility for the clinic with their GP or nurse.

- Display promotional material in the waiting room.
- Have the reception team give eligible patients a flyer asking them when they were last assessed. The patient can then take the flyer into their appointment with them, opening the door for a discussion with their Doctor or Nurse about relevant programs to assist.

Idea: Engaging the General Practice Team - Develop and maintain an effective recall and reminder system: staff education.

There is often a lot of work that needs to be done to improve how practices use software to maintain effective recall and reminder systems. Staff education is the first step towards improvement. Ask your Primary Care Improvement Officer to provide a short information session to staff and provide reminder and recall resource manuals.

Idea: Appoint a staff member who is responsible for creating and maintaining a register of patients eligible for the clinic, add this role to their job description.

This staff member may become the Practice Champion for the Nurse Led Clinic. Providing professional development opportunities to this staff member will assist with rewarding and recognising this person's contribution to the team.

Idea: Have a team meeting to brainstorm how recall and reminder systems could improve income generation and patient care.

(e.g. by linking together multiple recalls such as GP Management Plans, Health Assessments, clinic recalls etc.)

Dedicate some time at a staff meeting to discuss how health assessments can include prompts for assessing eligibility for the clinic. Review health assessment templates to ensure that eligibility questions are included.

Idea: Draft a written procedure for recall and reminder systems.

If your Practice has a policy/procedure for recalls and reminders, check that there is a process for 45-49 Health Assessment. If there is not a current policy, contact GPA or AGPAL as a starting point to generate conversation and development of a policy.

Idea: Send reminder letters to eligible patients due for assessment.

- Following the establishment of your Nurse Led Clinic patient register, identify patients due for assessment.
- The Nurse Led Clinic initiative suggests two key times where Practice reminders can really add value:
 1. For patients who have never been assessed
 2. On a patient's actual re-screen due date.
- Utilise the suggested template reminder letter available through your Primary Care Improvement Officer.

RESOURCES FOR UNDERTAKING QUALITY IMPROVEMENT

Quality Improvement Goal Setting

1. What are we trying to accomplish?

By answering this question, you will develop your goal for improvement.

2. How will we know that a change is an improvement?

By answering this question, you will develop measures to track the achievement of your goal.

3. What changes can we make that can lead to an improvement?

List your ideas for change. By answering this question, you will develop the ideas you would like to test towards achieving your goal.

IDEA 1.

IDEA 2.

IDEA 3.

IDEA 4.

Quality Improvement Action Worksheet

PLAN, DO, STUDY, ACT

Please complete a new worksheet for each change idea you have documented on the previous page.

Where there are multiple change ideas to test, please number the corresponding worksheet(s).

Describe the idea you are testing.

IDEA

Must include what, who, when, where, predictions & data to be collected.

What:

Who:

PLAN

When:

Where:

Data to collect/record:

What do we think will happen?

Was the plan executed? Document any unexpected events or problems.

DO

Record, analyse and reflect on the results.

Extract same data to measure for improvement:

STUDY

What will you take forward from this cycle (next step or next PDSA cycle)

ACT



Measuring Success

The overall aim of implementing a Nurse Led Clinic is to improve the quality and consistency of patient care, and to encourage the patient to become an active participant in their own healthcare.

Choosing an activity or idea to explore will have its own measure of success. It is important to identify in each activity what you are wanting to change and how you will know when the change has occurred.

Applying a SMARTA (Specific, Measurable, Attainable, Realistic, Timebound and Agreed) goal setting process will assist you.¹

SMARTA Goal Setting

- **Specific.** Goals that are too vague and general are hard to achieve, for example 'be a better parent'. Goals that work include specifics such as 'who, where, when, why and what'.
- **Measurable.** Ideally goals should include a quantity of 'how much' or 'how many' for example drinking 2 litres of water per day. This makes it easy to know when you have reached the goal.
- **Achievable.** Goals should be challenging, but achievable. Goals work best when they are neither too easy or too difficult. In many cases setting harder goals can lead to better outcomes, but only if the person can achieve it. Setting goals which are too difficult can be discouraging and lead to giving up altogether.
- **Relevant.** The goal should seem important and beneficial to the person who is assigned the goal.
- **Time-related.** 'You don't need more time, you just need a deadline.' Deadlines can motivate

efforts and prioritise the task above other distractions

- **Agreed.**

Reflect on the activity identified on page 11. Here you have undertaken a data analysis utilising PEN CS's CAT4 and this has shown the percentage of active patients who may be eligible for the clinic. This forms your baseline measure.

The next step is to decide on an activity and set a goal. For this example, you may like to set a goal to increase correct coding of mental health and chronic disease diagnoses by 10% through data cleansing and education of clinical staff. When this has been implemented within a set time frame, you can then repeat the data analysis to see the change in status has increased.

¹Health Direct November 2016 <https://www.healthdirect.gov.au/smart-goals>

An Example of Measuring Success - Skip for Life Clinic Example

Practice X has 600 active male and female patients aged between 18-65 years with a recorded mental health diagnosis and a chronic disease. Of these patients, following the use of CAT4 200 males and females in this age group have a recorded mental health diagnosis and a chronic disease but no documented care plan.

Numerator: The number of male and female patients aged 18-65 years, with 3 or more visits in the previous 2 years, who have a mental health diagnosis and a chronic disease but no documented care plan.

Denominator: The number of active male and female regular clients aged 18-65 years, who have a mental health diagnosis and a chronic disease.

$$[\text{Numerator of 200}] \div [\text{Denominator of 600}] = 30\%$$

Practice X then decides as a QI activity to undertake a data cleansing and improvement activity for mental health and chronic disease management. The measurement of change will be the increase in recording of 10%. This could be a measure after 3 months as this is a measurement of data management and system change.

Measurement for Nurse Led Clinic

Nurse Led Clinic Measure

NUMERATOR

DENOMINATOR

Nurse Led Clinic Measure

NUMERATOR

DENOMINATOR

Nurse Led Clinic Measure

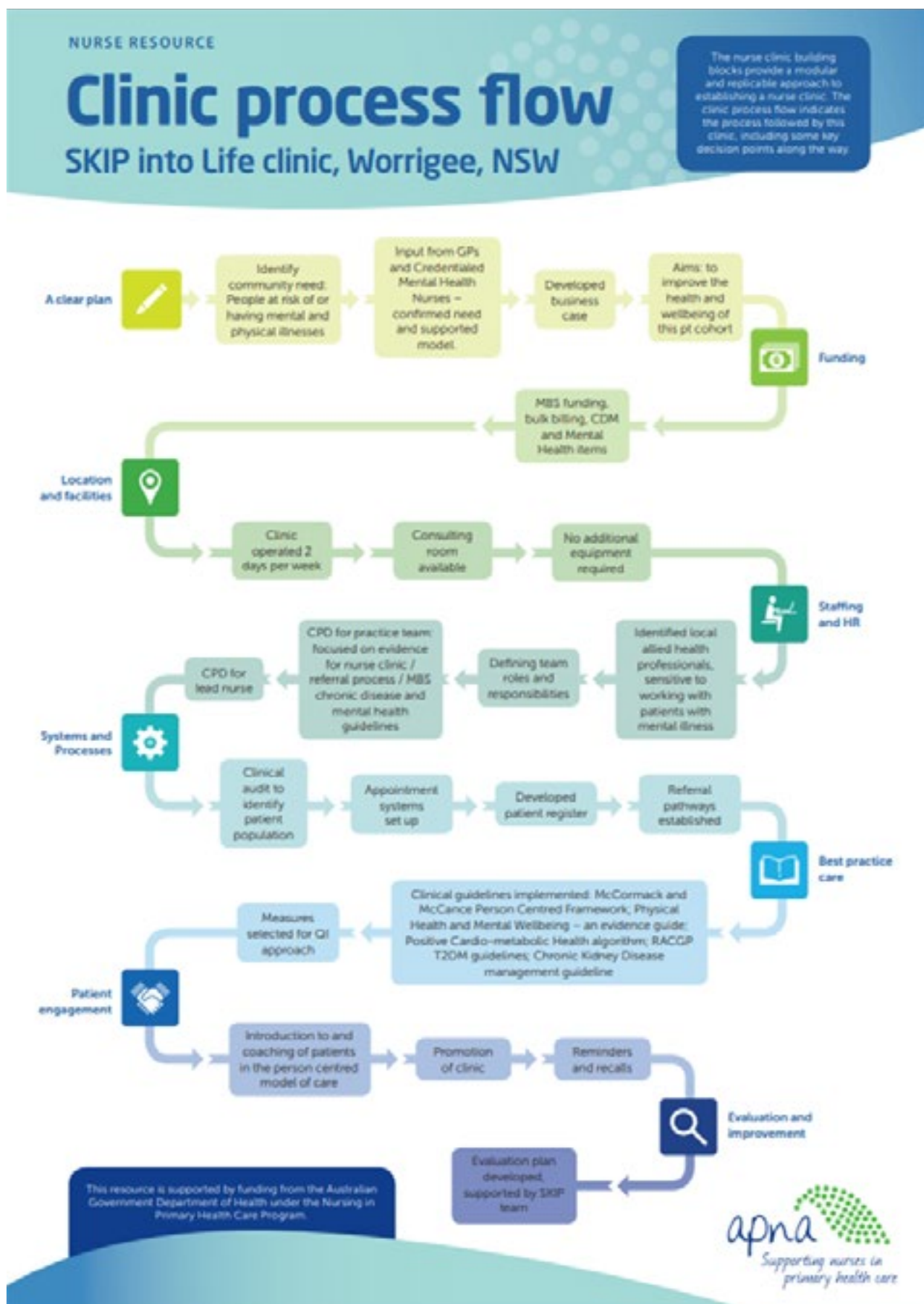
NUMERATOR

DENOMINATOR

Nurse Led Clinic Measure

NUMERATOR

DENOMINATOR



NURSE CLINIC RESOURCES – PATIENT FLOW

SKIP into life – Worrigee Medical Centre

This resource describes the patient criteria, activities and MBS billings associated with the SKIP into life – Worrigee Medical Centre.

Patient eligibility

Eligibility criteria

- GP referral
- Patient with identified mental illness
- Patient on psychotropic medication
- Patient with cardiometabolic risk factors
- Patient with high levels of psychological stress
- Patient with complex health needs
- Patient lost to follow up

What else do you need to know?

- Does the clinic meet a need in your community?
- What skills and training will you require?
- Who will be on the team?

[Visit our case study examples](#)

Initial visit

Clinical activities

- One hour consultation with the General Practice Nurse (GPN)
- Biopsychosocial assessment including cultural and economic aspects
- Patient education
- Assess readiness for referral
- Identify relevant referral pathway
- SKIP enrollment (if appropriate)
- GP consultation during GPN session

Follow up visits

- Frequency of follow up dependent on need, weekly to 4 monthly
- Occurs face-to-face or by phone
- Includes collaboration between GPN and GP, credentialed mental health nurse as required

Documentation

- Evidence of informed consent
- Coded reason for visit
- Past history & medication review
- Assessment priorities
- Patient needs and goals
- Completion of relevant template
- Suggested collaboration pathways
- Referrals as indicated
- Scheduled reminders
- Arrangements for follow up

Continued next page

NURSE CLINIC RESOURCES – PATIENT FLOW

SKIP into life - Worrige Medical Centre

MBS items

SKIP into Life MBS Item Numbers claimed (if eligible)

MBS Item #	Description	Recommended Frequency
23	GP Standard consultation (< 20mins) or 20 - 39mins	As required
36	GP Long consultation (>20, <40mins)	As required
705, 707	Health assessments 40 – 49 years 45 – 49 years 75+ years (Patient with an intellectual disability, Former serving members of the Australian Defence Force) >45mins or >60mins	1 per year, annually or 3 yearly dependent on category
715	Aboriginal And Torres Strait Islander Patients Health Assessment	Not more than once every 9 months
721*	GP Management Plan (GPMP)	Once per year
723*	Team Care Arrangement (TCA)	Once per year
732*	Review of GPMP and/or TCA	3 monthly
739/743	Case conferences	Up to 5 case conferences per year (time based)
900	Home Medicine Review	Not more than once in each 12 month period
2517	Completion Of A Cycle Of Care For Patients With Established Diabetes Mellitus	At least 11 months and up to 13 months
2700/2701	Mental health care plan 20mins or 40mins, without MH training.	Not more than once yearly
2712	Mental health care plan review	1 – 6 months after GP Mental Health Treatment plan
2713	GP MH consultation >20mins	Consult ≥ 20 minutes, for the ongoing management of a patient with mental disorder. No restriction on the number of these consultations per year.
2715/2717	Mental health care plan 20mins or 40mins, with MH training.	Not more than once yearly
10987	Follow up service for an Indigenous person who has received a health assessment	Maximum 10 annually
10991	Bulk billing incentive	Per eligible item number
10997	Follow up service for a person with a chronic disease	Maximum 5 annually
11506	Spirometry	As required
11610	Ankle Brachial Index	As required
11700	ECG	As required

The SKIP into life clinic is a 100% bulk billing service.

*A practice nurse, Aboriginal and Torres Strait Islander health practitioner, Aboriginal health worker or other health professional may assist a GP with items 721, 723, and 732 (e.g. in patient assessment, identification of patient needs and making arrangements for services). However, the GP must meet all regulatory requirements, review and confirm all assessments and see the patient.

Information provided related to the MBS was correct, as of December 2017.

Changes to the Practice Incentive Program will be introduced 1 May 2018.

This resource is supported by funding from the Australian Government Department of Health, under the Nursing in Primary Health Care Program.



NOTES:

Addendum and References:

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Useful Links:

- Nurse Led Clinics Building Blocks: <https://www.apna.asn.au/nursing-tools/nurse-clinics>
- Nurse Led Clinics Guide: <https://www.nursingtimes.net/roles/nurse-managers/nurse-led-clinics-10-essential-steps-to-setting-up-a-service/1931644.article>
- Desktop guide to Chronic Disease Management and MBS Item Numbers: <https://www.hneccphn.com.au/media/14146/new-desktop-guide-to-cdm-and-mbs-item-numbers-revised-february-2017.pdf>

PENCS CAT Recipe Links:

- <http://help.pencs.com.au/display/CR/Maximise+Business+Potential>
- <http://help.pencs.com.au/display/CR/Improve+Quality+of+Care+for+your+Patients>
- <http://help.pencs.com.au/display/CR/Identify+Patients+at+Risk>

HNECC PHN acknowledges the traditional owners and custodians of the lands that we live and work on as the First People of this Country.

This toolkit has been made possible through funding provided by the Australian Government under the PHN Program.

Guide published SEPTEMBER 2019