ASF PRIMARY HEALTH CLINIC STANDARDS

Complete Reference — Base Standard + 1 Endorsement

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Foreword

This standard originates from a deliberate policy choice made in Georgia in 2014: to advocate for international healthcare accreditation rather than attempt to replace it. Working through the Public Health Institute of Georgia (PHIG, established 2011), its founders organized the country's first structured accreditation initiative — including expert missions by Joint Commission International — and carried this advocacy directly to Georgia's Ministry of Health over the following years.

That advocacy produced, in 2018, the first draft of a Georgian-adapted accreditation standard, and in 2020, the formal establishment of Accréditation Sans Frontières (ASF) as an international legal entity in Paris, alongside the ASF International Standards Council — the standing body responsible for developing and revising ASF's standards. The Council's methodology is directly informed by the World Health Organization's guideline development process, including WHO's use of the GRADE framework for weighing evidence certainty, adapted to the practical work of accreditation. ASF's founder has served since 2016 as a founding member of the UN Secretary-General's Independent Accountability Panel for Every Woman, Every Child, Every Adolescent, and ASF has been a member of the International Society for Quality in Health Care (ISQua) since 2023.

This advocacy also found regulatory validation in Georgian government policy requiring independent international accreditation of hospitals, formally implemented through Order №4/б (26 January 2023).

Consistent with the structure recognized across major international standards bodies, ASF's work spans four pillars: accreditation of organizations against its published standards, accreditation of the standards themselves through the International Standards Council's ongoing review, accreditation of the surveyors who conduct ASF's own assessments, and accreditation of the training that equips facilities and professionals to meet them, delivered through GMJ Academy. This standard has been developed and refined through consultation with practitioners across multiple continents, and every edition includes a Health & Migration endorsement grounded in WHO's Global Competency Standards for health workers serving refugees and migrants — a commitment ASF treats as non-negotiable. Consistent with ASF's founding principle of accreditation without borders, this standard is published in full and made freely available to any organization seeking to build accreditation capacity in its own country.

This, the third edition, is published in 2026. The ASF International Standards Council reviews and revises each standard on a three-year cycle.

About This Document

This is the ASF Primary Health Clinic complete standard — seven mandatory base standards covering the full patient journey through any primary care practice, from a solo family physician to a multi-provider clinic, plus one built endorsement layering onto that base: Health & Migration. No endorsement is ever issued alone — it is only assessed after the base standard is genuinely met in full.

Every criterion follows the same two-page structure established across ASF's standards: an assessment page (a facility self-assessment table, and exactly what an ASF assessor will independently check) and a guidance page (why the standard exists, what good and failure look like, how to implement from zero).

Every criterion carries at least one reference. Numbered references are formal, individually verified Vancouver-style citations; where a criterion instead reflects genuine professional consensus without one attributable paper, that is stated honestly rather than assigned an invented citation.

Immediately after this page is the Facility Classification chapter — the same four-type model already established for ASF's Hospital standard, adapted for primary health clinics specifically: Crisis, Transitional, Small, or Standard.

Alignment With ISO 9001:2015

This standard's governance structure — Standard 7 — is deliberately built to reflect the core management principles of ISO 9001:2015, the international quality management system standard [7]. This is a statement of structural alignment, not a claim of certification: ISO 9001:2015 compliance is a formal status determined only through accredited external audit, which this document does not confer. The table below shows the mapping honestly, clause by clause.

ISO 9001:2015 CLAUSE	WHERE THIS STANDARD REFLECTS IT
Clause 4 — Context of the Organization	Not directly covered — outside this standard's clinical patient-safety scope.
Clause 5 — Leadership	7.1 — Leadership Is Real and Accountable
Clause 6 — Planning	3.4 (Risk Register) and 7.8 (Quality Objectives Are Set, Specific, and Tracked)
Clause 7 — Support	4.2 (Credentials), 7.4 (Records), 7.6 (Scope of Practice)
Clause 8 — Operation	Standard 4 (Care & Treatment) in full
Clause 9 — Performance Evaluation	7.7 — Leadership Reviews Overall Performance at Planned Intervals
Clause 10 — Improvement	7.5 (Incident Reporting) and 7.9 (Continual Improvement Process)

Facility Classification — Which Type of Primary Health Clinic Are You?

Four Facility Types, Not One

The same four-category model built for ASF's Hospital standard applies here, with one deliberate change: Small is anchored to a genuine, real-world unit for primary care — a single doctor. Primary care, unlike a hospital or a 24-hour residential facility, can be and very often is delivered by exactly one physician, especially in rural and crisis-affected settings.

Standard (ST)

A fully resourced, functioning primary health clinic — a full multi-provider team, on-site diagnostics, no adaptation needed.

Small (SM) — where staffing depth, not crisis or poverty, is the defining constraint

Exactly one doctor is the confirmed anchor. This is not a research threshold requiring external verification — it is the plain, real unit of primary care itself: a solo family physician, otherwise stable, genuinely limited only by being one person doing what a larger team would otherwise share.

Transitional (TR)

Real national resource or infrastructure limitation, no active conflict — the same World Bank-anchored logic used throughout ASF's standards.

Crisis (CR)

Active conflict or humanitarian emergency — overrides every other consideration, exactly as in the Hospital standard.

The Universal Floor

A small number of criteria apply in full, in every one of the four types, with no exceptions: correct patient identification, genuine hand hygiene, real informed consent, dignity and non-discrimination, and — specific to primary care — genuine continuity, meaning a patient's own medical history is actually known and used, not treated as a new encounter every visit.

Which Type of Primary Health Clinic Are You?

Answer these questions in order, top to bottom. The moment you answer YES, stop — that is your answer. If you reach the end still answering NO, you are Standard.

WORK DOWN THIS LIST. STOP AT YOUR FIRST YES.			
1	**Is your country in an active war, armed conflict, or a declared humanitarian emergency right now?** *This means fighting, displacement, or a declared emergency is actually happening now — not that things are generally difficult.*	☐ **YES → CR CRISIS**	☐ NO → next question
2	**Does your national government struggle badly to fund healthcare, or is national power or medicine supply unreliable — even though there is no war or crisis?** *This is about your country as a whole, not just your own facility.*	☐ **YES → TR TRANSITIONAL**	☐ NO → next question
3	**Is your clinic staffed by exactly one doctor, and is that the main reason you cannot offer certain services — for example, same-day coverage during your own absence, or a broader range of on-site chronic disease management?** *This applies even in a stable, well-funded country. A genuine solo practice, not a small team — the limit here is being one person, nothing else.*	☐ **YES → SM SMALL**	☐ NO → next question
If you answered NO to all three questions above: You are **STANDARD (ST)** — no crisis, no national constraint, and staffing depth is not holding you back.			

THIS IS ME

My type: ☐ **CR** ☐ **TR** ☐ **SM** ☐ **ST**

Example: A solo family doctor in rural Moldova — no active conflict, so NO to question 1. National healthcare funding is genuinely unreliable, so YES to question 2. Stop there. This clinic is TR.

Verified, not just accepted, on the assessor's visit. If reality is different from what you ticked, the classification is corrected on the spot.

Table of Contents

STANDARD 1

Patient Registration & Continuity of Care

MANDATORY

5 criteria

	Standard 1.1 **NON-NEGOTIABLE** · *Standard 1: Patient Registration & Continuity of Care* **Every Patient Is Empaneled to a Specific, Named Clinician**	**ASSESSMENT** ASF-PHC-STD1-v3.0

CR ADAPTED	**TR** FULL	**SM** FULL	**ST** FULL

1.1
NON-NEGOTIABLE
L1

THE STANDARD

Every Patient Is Empaneled to a Specific, Named Clinician

Every registered patient is formally empaneled — assigned to a specific, named clinician or care team responsible for their ongoing care — not simply added to a general patient list with no defined, accountable relationship.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is every registered patient formally empaneled to a specific, named clinician or care team?** *A real, specific assignment, not a general patient list with no defined accountability.* Doc: Empanelment record	YES	PARTIAL	NO
2	**Is empanelment genuinely sensitive to patient and family preference, not assigned arbitrarily?** *Genuine consideration of preference, not a mechanical assignment process alone.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Can a patient or staff member identify exactly who this patient's primary clinician is, without ambiguity?** *A clear, unambiguous answer, not uncertainty about who is actually responsible.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Empanelment record review*	Reviews records for a sample of patients to confirm genuine, specific empanelment.
ASK *Preference sensitivity interview*	Asks staff how empanelment accounts for patient and family preference.
ASK *Clinician identification check*	Asks a patient or staff member to identify a specific patient's assigned clinician.

REFERENCES

[1] Empanelment is the act of assigning individual patients to individual primary care providers and care teams with sensitivity to patient and family preference, and is established as the basis for population health management and therapeutic continuity in primary care practice.

Standard 1.1 · *Standard 1: Patient Registration & Continuity of Care*

Guidance & Learning

GUIDANCE ASF-PHC-STD1-v3.0

WHY THIS STANDARD EXISTS

Empanelment is the actual mechanism that makes primary care primary care — without a specific clinician genuinely accountable for a patient's ongoing health, care fragments into a series of disconnected encounters with whoever happens to be available, losing exactly the continuity that gives primary care its real value.

The evidence: [1] Empanelment is the act of assigning individual patients to individual primary care providers and care teams with sensitivity to patient and family preference, and is established as the basis for population health management and therapeutic continuity in primary care practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every patient is genuinely, specifically empaneled to a named clinician or team.	✗ Patients are added to a general list with no specific, accountable assignment.
✓ Empanelment genuinely considers patient and family preference.	✗ Empanelment is mechanical, with no genuine consideration of preference.
✓ Anyone can clearly identify a patient's assigned clinician without ambiguity.	✗ Staff or patients are uncertain who is actually responsible for a patient's care.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Empanelment happens for most patients but new registrations sometimes wait before formal assignment.**
The protective value of empanelment applies from the first visit, not after an administrative delay.

2 **Assignment is specific but doesn't account for a patient's stated preference for a particular clinician.**
Genuine sensitivity to preference is part of what makes the relationship therapeutic, not just administrative.

3 **Empanelment records exist but aren't consistently updated when a clinician leaves the practice.**
A patient's empanelment needs to reflect who is actually currently responsible for their care.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current registration practice for genuine, specific empanelment versus general list addition.

Week 2 Establish a formal empanelment process considering patient and family preference.

Week 3 Build a clear, accessible record of each patient's current empaneled clinician.

Ongoing Update empanelment promptly when clinician staffing changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a random patient in the waiting room who their assigned doctor is.
A confident, specific answer reveals genuine empanelment, not assumed continuity.

Ask what happens to empanelment when a clinician leaves the practice.
A specific, confident answer reveals a genuine, maintained process, not one that quietly goes stale.

E-LEARNING academy.gmj.ge/phc-std1-1-empanelment — 30 min · complete before self-assessment

Standard 1.2 **NON-NEGOTIABLE** · *Standard 1: Patient Registration & Continuity of Care*

A Patient's Own Medical History Is Actually Known and Used, Not Treated as a New Encounter Each Visit

ASSESSMENT ASF-PHC-STD1-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

1.2
NON-NEGOTIABLE
L1

THE STANDARD

A Patient's Own Medical History Is Actually Known and Used, Not Treated as a New Encounter Each Visit

A patient's relevant medical history, prior visits, and ongoing issues are genuinely reviewed and actively used at each visit — not treated as a fresh encounter each time, with the clinician relying only on what the patient happens to mention that day.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is a patient's relevant history genuinely reviewed before or during each visit, not relied on solely from what they mention that day?** *Real, active review of the actual record, not passive reliance on patient recall alone.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Are ongoing issues from prior visits actively followed up, not lost between encounters?** *Genuine, tracked follow-through, not issues that quietly drop between visits.* Doc: Ongoing issue tracking record	YES	PARTIAL	NO
3	**Can the clinician describe specific, relevant history for a patient without the patient having to repeat it?** *Genuine, demonstrated knowledge, not dependence on the patient re-explaining their own history each time.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *History review observation*	Observes an actual visit for genuine review and use of the patient's existing history.
DOCUMENT *Follow-up tracking review*	Reviews whether ongoing issues from prior visits are tracked and genuinely followed up.
ASK *Patient experience interview*	Asks a patient whether they feel they have to re-explain their history at each visit.

REFERENCES

[2] Retrospective analysis of linked health administrative data found continuity of care with an individual family physician is associated with reduced emergency department visits and hospitalizations across varying levels of patient complexity, establishing relational continuity as a mechanism with genuine, measurable clinical benefit.

Standard 1.2 · *Standard 1: Patient Registration & Continuity of Care*

Guidance & Learning

GUIDANCE ASF-PHC-STD1-v3.0

WHY THIS STANDARD EXISTS

Relational continuity — a genuine, ongoing relationship where the clinician actually knows the patient's history — is the core, evidence-based mechanism through which primary care improves outcomes, and a practice that doesn't genuinely use this history at each visit provides none of continuity's real, documented benefit, regardless of whether the same clinician is technically assigned.

The evidence: [2] Retrospective analysis of linked health administrative data found continuity of care with an individual family physician is associated with reduced emergency department visits and hospitalizations across varying levels of patient complexity, establishing relational continuity as a mechanism with genuine, measurable clinical benefit.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ History is genuinely reviewed and actively used at each visit.	✗ Each visit is treated as a fresh encounter, relying on what the patient mentions that day.
✓ Ongoing issues are actively tracked and followed up, not lost between visits.	✗ Ongoing issues from prior visits are lost or not followed up.
✓ Patients don't have to repeatedly re-explain their own history.	✗ Patients regularly find themselves re-explaining history the practice should already know.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **History review happens for complex, chronic patients but less consistently for those with simpler needs.**
Every patient benefits from genuine continuity, not only those with the most complex conditions.

2 **Review happens when the same clinician sees the patient but less reliably when a covering clinician is involved.**
Continuity of information should hold even when the usual clinician isn't the one seeing the patient that day.

3 **Follow-up tracking exists but isn't consistently checked before the next relevant visit.**
A tracking system that isn't actively checked provides limited real protective value.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine history review versus fresh-encounter treatment.

Week 2 Establish a standard pre-visit history review step for every patient, including with covering clinicians.

Week 3 Build an active ongoing-issue tracking and follow-up process.

Ongoing Audit whether tracked issues are genuinely being followed up.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient whether they feel their doctor genuinely remembers their history.
This tests lived experience of continuity, not administrative record-keeping alone.

Observe a visit with a covering clinician specifically.
This is where genuine use of existing history is most likely to lapse.

E-LEARNING academy.gmj.ge/phc-std1-2-history-continuity — 30 min · complete before self-assessment

Standard 1.3 **CORE** · *Standard 1: Patient Registration & Continuity of Care*

Continuity Is Actively Measured, Not Assumed

ASSESSMENT ASF-PHC-STD1-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

1.3
CORE
L1

THE STANDARD

Continuity Is Actively Measured, Not Assumed

The practice actively measures its own continuity of care — the proportion of a patient's visits that are genuinely with their own empaneled clinician or team — not assuming continuity is adequate without ever actually checking.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the practice actively calculate a real continuity measure, not assume continuity is adequate?** *A genuine, calculated measure, not an unverified assumption.* Doc: Continuity measurement record	YES	PARTIAL	NO
2	**Is this measure reviewed regularly, not calculated once and forgotten?** *Genuine, ongoing review, not a one-time calculation.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**When continuity is found to be low for a specific patient or pattern, is there a genuine response?** *Real, active response to a low result, not a measure tracked without consequence.* Doc: Low-continuity response record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Continuity measurement review*	Reviews whether the practice genuinely calculates a real continuity metric.
DOCUMENT *Review frequency check*	Reviews how regularly the continuity measure is actually reviewed.
ASK *Low-continuity response interview*	Asks staff what happens when continuity is found to be low for a specific pattern or patient.

REFERENCES

[3] The Usual Provider of Care Index, defined as the proportion of a patient's visits with their own designated primary care provider, is an established, validated metric for measuring genuine continuity of care in primary care practice.

Standard 1.3 · *Standard 1: Patient Registration & Continuity of Care*

Guidance & Learning

GUIDANCE ASF-PHC-STD1-v3.0

WHY THIS STANDARD EXISTS

A practice that doesn't measure its own continuity has no real way of knowing whether the relational continuity it depends on for better outcomes is actually happening in practice, or has quietly eroded as scheduling pressures and staff changes accumulate over time.

The evidence: [3] The Usual Provider of Care Index, defined as the proportion of a patient's visits with their own designated primary care provider, is an established, validated metric for measuring genuine continuity of care in primary care practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuine continuity measure is actively calculated, not assumed.	✗ No real continuity measure exists; adequacy is simply assumed.
✓ The measure is reviewed regularly, not calculated once and forgotten.	✗ A measure exists but is calculated once and never revisited.
✓ Low continuity triggers a genuine, active response.	✗ Low continuity, if identified, produces no real response.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A continuity measure exists but is calculated for the practice as a whole, not for individual clinicians.**
Practice-wide averages can mask genuine variation that matters for specific patients or clinicians.

2 **Review happens periodically but isn't tied to any specific threshold that would trigger action.**
A measure without a genuine action threshold provides limited real value for improvement.

3 **Low continuity is identified for specific patients but a systemic pattern across the practice isn't reviewed collectively.**
Individual cases and systemic patterns each deserve genuine attention.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine continuity measurement versus assumed adequacy.

Week 2 Establish a real, calculated continuity measure at both individual and practice level.

Week 3 Define a specific threshold that triggers genuine review and action.

Ongoing Review continuity measures regularly and act on identified patterns.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the practice's actual, calculated continuity figure, not a general impression.
A specific, real number reveals genuine measurement, not an assumption.

Ask what happened the last time continuity was found to be low for a specific pattern.
A real example reveals whether measurement leads to genuine action.

E-LEARNING academy.gmj.ge/phc-std1-3-continuity-measurement — 30 min · complete before self-assessment

Standard 1.4 **CORE** · *Standard 1: Patient Registration & Continuity of Care*

Registration Captures What Actually Matters for Ongoing Care

ASSESSMENT ASF-PHC-STD1-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

1.4
CORE
L1

THE STANDARD

Registration Captures What Actually Matters for Ongoing Care

Patient registration captures genuinely relevant information for ongoing primary care — chronic conditions, family history, social context affecting health — not only administrative and billing information, treated as sufficient on its own.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Does registration genuinely capture chronic conditions, family history, and relevant social context, not only administrative details?** *Real, clinically relevant information, not billing and contact details alone.* Doc: Registration content documentation	YES	PARTIAL	NO
2	**Is this information actively used to inform the patient's early care, not collected and left unused?** *Genuine, early use of registration information, not documentation without follow-through.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is registration information genuinely updated over time, not treated as fixed from the first visit?** *Real, ongoing updates, not information that grows stale as the patient's circumstances change.* Doc: Registration update record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Registration content review*	Reviews registration records for genuine clinical and social content, not administrative information alone.
OBSERVE *Early use observation*	Observes whether registration information genuinely informs a patient's early care.
DOCUMENT *Update record review*	Reviews whether registration information is genuinely updated over time.

REFERENCES

[4] Comprehensive intake capturing chronic conditions, family history, and social context, distinct from administrative registration alone, is established practice in primary care literature as foundational to effective population health management and individualized care.

Standard 1.4 · *Standard 1: Patient Registration & Continuity of Care*

Guidance & Learning

GUIDANCE ASF-PHC-STD1-v3.0

WHY THIS STANDARD EXISTS

Registration is the foundation the entire ongoing relationship builds on, and a registration process focused only on administrative necessity misses information that genuinely shapes what good primary care looks like for this specific patient from the very first visit.

The evidence: [4] Comprehensive intake capturing chronic conditions, family history, and social context, distinct from administrative registration alone, is established practice in primary care literature as foundational to effective population health management and individualized care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Registration genuinely captures relevant clinical and social information, not administrative details alone.	✗ Registration focuses only on administrative and billing information.
✓ This information actively informs the patient's early care.	✗ Collected information isn't used to inform actual early care.
✓ Registration information is genuinely updated as circumstances change.	✗ Registration information remains static from the first visit onward.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Chronic conditions are captured well but family history is inconsistently collected.**
Family history carries real, genuine relevance for preventive care planning.

2 **Social context is asked about but not consistently connected to actual care planning.**
Information that doesn't inform care provides limited real value beyond documentation.

3 **Registration is thorough at the first visit but rarely revisited as a patient's life circumstances change.**
A patient's relevant social and family context can genuinely change over the course of an ongoing relationship.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current registration content for genuine clinical and social relevance.

Week 2 Build a structured intake capturing chronic conditions, family history, and social context.

Week 3 Establish a process connecting registration information to early care planning.

Ongoing Revisit and update registration information periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see a specific patient's registration record for genuine clinical and social content.
A real, specific record reveals whether this is genuine practice, not administrative intake alone.

Ask how registration information from a patient's first visit informed their actual early care.
A specific, real example reveals genuine use, not documentation for its own sake.

E-LEARNING academy.gmj.ge/phc-std1-4-registration-content — 30 min · complete before self-assessment

Standard 1.5 **NON-NEGOTIABLE** · *Standard 1: Patient Registration & Continuity of Care*

A Patient Can Reach Their Own Clinician or Care Team, Not Just Whoever Is Available

ASSESSMENT ASF-PHC-STD1-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

1.5
NON-NEGOTIABLE
L1

THE STANDARD

A Patient Can Reach Their Own Clinician or Care Team, Not Just Whoever Is Available

A patient has a genuine, defined way to reach their own empaneled clinician or care team for an ongoing issue — not only the option of whoever happens to be available that day, with no real path back to the clinician who actually knows their history.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does a patient have a genuine, defined way to reach their own empaneled clinician or team?** *A real, specific pathway, not default routing to whoever is available.* Doc: Patient contact pathway documentation	YES	PARTIAL	NO
2	**Is this pathway genuinely known to patients, not just theoretically available?** *Real, communicated awareness, not an option patients don't know exists.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**When the patient's own clinician genuinely isn't available, is there a defined handoff that preserves relevant history?** *A real, structured handoff, not a complete loss of continuity when the usual clinician is out.* Doc: Coverage handoff protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Contact pathway review*	Reviews the actual, defined pathway for patients to reach their own clinician or team.
ASK *Patient awareness interview*	Asks a patient whether they know how to reach their own assigned clinician.
DOCUMENT *Coverage handoff review*	Reviews the structured handoff process when the patient's own clinician is unavailable.

REFERENCES

[5] A genuine, defined pathway for patients to reach their own assigned clinician or care team, distinct from default routing to any available provider, is established practice for preserving the real value of primary care continuity.

Standard 1.5 · *Standard 1: Patient Registration & Continuity of Care*

Guidance & Learning

GUIDANCE ASF-PHC-STD1-v3.0

WHY THIS STANDARD EXISTS

Empanelment only delivers its real value if a patient can genuinely reach the clinician they're actually assigned to when it matters — a system where every contact defaults to whoever is available undermines the entire continuity relationship this standard exists to protect.

The evidence: [5] A genuine, defined pathway for patients to reach their own assigned clinician or care team, distinct from default routing to any available provider, is established practice for preserving the real value of primary care continuity.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuine, defined pathway lets patients reach their own clinician or team.	✗ Patients default to whoever is available, with no real path to their own clinician.
✓ Patients are genuinely aware this pathway exists.	✗ Patients are unaware any specific pathway to their own clinician exists.
✓ A structured handoff preserves relevant history when the usual clinician is unavailable.	✗ No structured handoff exists, and continuity is lost when the usual clinician is out.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A pathway exists for scheduled appointments but not for urgent same-day needs.**
Continuity matters as much, if not more, in urgent moments as in scheduled ones.

2 **Patients are told about the pathway once at registration but it isn't reinforced over time.**
A pathway mentioned once, long ago, is easily forgotten by the time a patient actually needs it.

3 **Coverage handoff happens but relevant history isn't consistently communicated to the covering clinician.**
A handoff without genuine information transfer doesn't preserve the real value of continuity.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current patient contact pathways for genuine access to their own clinician.

Week 2 Establish a clear, communicated pathway for both scheduled and urgent contact.

Week 3 Build a structured coverage handoff process preserving relevant patient history.

Ongoing Reinforce pathway awareness with patients periodically, not only at initial registration.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient directly how they would reach their own doctor for an urgent concern.
A confident, specific answer reveals a genuine, known pathway, not an assumed one.

Ask what information a covering clinician actually receives when the usual clinician is unavailable.
A specific, real answer reveals whether handoff genuinely preserves continuity.

E-LEARNING academy.gmj.ge/phc-std1-5-clinician-access — 30 min · complete before self-assessment

STANDARD 2

Preventive Care & Screening

MANDATORY

5 criteria

Standard 2.1 **NON-NEGOTIABLE** · *Standard 2: Preventive Care & Screening*

Preventive Care Is Systematically Tracked, Not Relied on From Memory

ASSESSMENT ASF-PHC-STD2-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

2.1
NON-NEGOTIABLE
L1

THE STANDARD

Preventive Care Is Systematically Tracked, Not Relied on From Memory

The practice uses a systematic tracking process to identify which evidence-graded preventive services each patient is due for, based on age, sex, and risk factors — not relying on a clinician remembering to consider this during a visit already focused on the patient's presenting concern.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the practice use a systematic process to identify which preventive services each patient is due for?** *A real, structured tracking system, not reliance on the clinician remembering during a busy visit.* Doc: Preventive care tracking system documentation	YES	PARTIAL	NO
2	**Does this tracking genuinely account for the patient's actual age, sex, and risk factors, not a generic checklist?** *Individualized, accurate tracking, not a one-size-fits-all list.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is the tracking system actively used at or before each visit, not maintained separately from actual care?** *Genuine, integrated use, not a system that exists without informing real encounters.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Tracking system review*	Reviews the actual tracking system used to identify due preventive services.
DOCUMENT *Individualization review*	Reviews whether tracking accurately reflects individual patient age, sex, and risk factors.
OBSERVE *Visit integration observation*	Observes whether the tracking system is genuinely consulted at or before an actual visit.

REFERENCES

[6] Research estimates that delivering all recommended preventive services for a standard patient panel would require approximately 14.1 hours per day on top of acute and chronic disease care, with surveyed primary care providers reporting they prioritize only one to three preventive services per visit due to time constraints.

Standard 2.1 · *Standard 2: Preventive Care & Screening*

Guidance & Learning

GUIDANCE ASF-PHC-STD2-v3.0

WHY THIS STANDARD EXISTS

Delivering every recommended preventive service to a full patient panel would take more hours in a day than exist, and research shows clinicians under real time pressure default to prioritizing only one to three preventive services per visit — a systematic tracking process is what prevents this real constraint from quietly becoming ad hoc, memory-dependent neglect of services a specific patient is actually due for.

The evidence: [6] Research estimates that delivering all recommended preventive services for a standard patient panel would require approximately 14.1 hours per day on top of acute and chronic disease care, with surveyed primary care providers reporting they prioritize only one to three preventive services per visit due to time constraints.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A real, systematic tracking process identifies due preventive services for every patient.	✗ Preventive care identification relies on clinician memory during busy visits.
✓ Tracking genuinely reflects individual age, sex, and risk factors.	✗ Tracking is generic, not reflecting the specific patient's actual risk profile.
✓ The system is actively consulted and used, not maintained separately from real care.	✗ A tracking system exists but isn't genuinely consulted during real encounters.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Tracking exists for common services like blood pressure but not for less frequently considered ones like lung cancer screening.**
Every genuinely indicated service deserves the same systematic tracking, not only the most familiar ones.

2 **The system flags due services but doesn't account for a patient's specific risk factors beyond basic demographics.**
Genuine individualization requires more than age and sex alone for many preventive services.

3 **Tracking is reviewed for scheduled visits but not consulted during same-day or urgent encounters.**
A preventive care opportunity during any visit type is a genuine opportunity worth capturing.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current preventive care identification practice for reliance on memory versus systematic tracking.

Week 2 Build or strengthen a systematic tracking process reflecting individual patient risk factors.

Week 3 Integrate tracking consultation into standard visit workflow, including same-day visits.

Ongoing Audit tracking accuracy and actual use across visit types.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual tracking system for a specific patient and compare against their real risk profile.
A real, specific example reveals genuine individualization, not a generic checklist.

Ask a clinician how they identify due preventive services during a same-day, non-preventive visit.
This reveals whether tracking genuinely extends beyond scheduled preventive visits.

E-LEARNING academy.gmj.ge/phc-std2-1-preventive-tracking — 30 min · complete before self-assessment

Standard 2.2 **NON-NEGOTIABLE** · *Standard 2: Preventive Care & Screening*

Preventive Care Delivery Doesn't Depend on the Patient Remembering to Ask

ASSESSMENT ASF-PHC-STD2-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

2.2
NON-NEGOTIABLE
L1

THE STANDARD

Preventive Care Delivery Doesn't Depend on the Patient Remembering to Ask

The practice proactively offers grade A and B preventive services when a patient is due — flagged, discussed, and offered as a matter of standard practice — not delivered only when a patient happens to specifically ask about a particular screening or vaccination.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Are grade A and B preventive services proactively offered when a patient is due, not only when specifically requested?** *Genuine, proactive offering, not passive availability dependent on patient initiative.* Doc: Proactive offering documentation	YES	PARTIAL	NO
2	**Does proactive offering happen consistently regardless of the patient's apparent health literacy or assertiveness?** *Equal, consistent proactive practice, not dependent on how informed or confident a specific patient seems.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there real evidence that proactive offering actually results in higher completion, not just occurs without measurable effect?** *Genuine, measurable impact, not an assumption that offering alone is sufficient.* Doc: Completion rate evidence	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

OBSERVE *Proactive offering observation*	Observes actual visits for genuine proactive offering of due preventive services.
ASK *Consistency interview*	Asks staff whether proactive offering happens consistently regardless of patient assertiveness.
DOCUMENT *Completion evidence review*	Reviews whether proactive offering correlates with genuine completion rate improvement.

REFERENCES

[7] Established evidence-graded preventive service recommendation systems identify high-priority services as those with high or moderate net benefit for eligible patients, recognized in various forms across many countries' preventive care guidance.

Standard 2.2 · *Standard 2: Preventive Care & Screening*

Guidance & Learning

GUIDANCE ASF-PHC-STD2-v3.0

WHY THIS STANDARD EXISTS

A patient who doesn't know a specific service exists, or doesn't think to ask, shouldn't be less likely to receive genuinely beneficial, evidence-graded preventive care than a patient who happens to be more informed or assertive — proactive offering is what makes preventive care actually equitable, not dependent on the patient's own health literacy or confidence to ask.

The evidence: [7] Established evidence-graded preventive service recommendation systems identify high-priority services as those with high or moderate net benefit for eligible patients, recognized in various forms across many countries' preventive care guidance.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Grade A and B services are genuinely, proactively offered when due.	✗ Preventive services are delivered only when a patient specifically asks.
✓ Proactive offering happens consistently regardless of patient assertiveness or literacy.	✗ Proactive offering varies based on how informed or assertive a specific patient seems.
✓ Real evidence shows proactive offering genuinely improves completion.	✗ No evidence connects proactive offering to genuine completion improvement.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Offering happens for well-known services like vaccination but less consistently for less familiar screenings.**
Every grade A or B service deserves the same proactive practice, not only the most commonly discussed ones.

2 **Proactive offering happens during dedicated preventive visits but not during other visit types.**
Any visit is a genuine opportunity to proactively offer a due service.

3 **Offering is generally consistent but staff report being less thorough during high-volume periods.**
Genuine equity in preventive care delivery shouldn't depend on how busy the practice happens to be.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current preventive care delivery for reliance on patient-initiated requests.

Week 2 Establish a standard proactive offering practice across all visit types.

Week 3 Train staff on consistent offering regardless of patient assertiveness or literacy.

Ongoing Track completion rates to confirm proactive offering is genuinely improving uptake.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual visit where a patient doesn't raise preventive care themselves.
This tests whether proactive offering genuinely happens, not just when the patient prompts it.

Ask about offering practice specifically during a high-volume period.
This is where proactive practice is most likely to lapse under real pressure.

E-LEARNING academy.gmj.ge/phc-std2-2-proactive-offering — 30 min · complete before self-assessment

Standard 2.3 **CORE** · *Standard 2: Preventive Care & Screening*

Screening Completion Rates Are Actively Measured and Acted On

ASSESSMENT ASF-PHC-STD2-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

2.3
CORE
L1

THE STANDARD

Screening Completion Rates Are Actively Measured and Acted On

The practice actively measures its own completion rates for key preventive screenings across its patient panel, with a genuine response when rates fall short — not a general sense that screening happens without ever actually checking the real numbers.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Does the practice actively measure its own completion rates for key preventive screenings across its panel?** *Real, calculated completion data, not a general assumption of adequacy.* Doc: Screening completion rate documentation	YES	PARTIAL	NO
2	**Is there a genuine response when completion rates for a specific screening fall short?** *Real, active improvement effort, not a rate tracked without consequence.* Doc: Completion rate response record	YES	PARTIAL	NO
3	**Is completion measured for the full eligible panel, not just patients who happen to attend preventive-focused visits?** *Genuine, full-panel measurement, not a skewed sample of already-engaged patients.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Completion rate measurement review*	Reviews whether the practice genuinely calculates real completion rates for key screenings.
DOCUMENT *Response to shortfall review*	Reviews evidence of genuine action when completion rates are found to fall short.
DOCUMENT *Panel coverage review*	Reviews whether measurement covers the full eligible panel, not only actively engaged patients.

REFERENCES

[8] National data from multiple countries document a persistent gap between long-established, high-priority screening recommendations and actual completion rates, demonstrating that completion rates require active measurement rather than assumed adequacy.

Standard 2.3 · *Standard 2: Preventive Care & Screening*

Guidance & Learning

GUIDANCE ASF-PHC-STD2-v3.0

WHY THIS STANDARD EXISTS

Real-world completion rates for even well-established, widely recommended screenings can be genuinely lower than assumed, and a practice that doesn't measure its own actual performance has no way of knowing whether real gaps exist in its population, or of directing genuine improvement effort where it's actually needed.

The evidence: [8] National data from multiple countries document a persistent gap between long-established, high-priority screening recommendations and actual completion rates, demonstrating that completion rates require active measurement rather than assumed adequacy.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Real completion rates are actively measured for key screenings.	✗ Screening adequacy is assumed without genuine measurement.
✓ A genuine response follows when rates are found to fall short.	✗ Low completion rates, if identified, produce no real response.
✓ Measurement covers the full eligible panel, not only engaged patients.	✗ Measurement only captures patients who already attend regularly, missing disengaged patients.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Completion is measured for one or two screenings but not systematically across all key services.**
Every key preventive screening benefits from the same genuine measurement discipline.

2 **A shortfall is identified but the response addresses only the immediate finding, not the underlying reason for the gap.**
Genuine improvement requires understanding why a gap exists, not just noting that it does.

3 **Measurement happens but doesn't specifically account for patients who haven't visited the practice recently.**
Disengaged patients are often exactly where the real screening gaps exist.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current screening completion measurement for real, panel-wide coverage.

Week 2 Establish systematic completion rate calculation for key preventive screenings.

Week 3 Build a genuine response process for identified shortfalls, addressing underlying causes.

Ongoing Review completion rates regularly and track improvement over time.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the practice's actual, current completion rate for a specific screening, not a general impression.
A specific, real number reveals genuine measurement, not an assumption.

Ask what the practice did the last time a completion rate was found to be genuinely low.
A real example reveals whether measurement leads to real action.

E-LEARNING academy.gmj.ge/phc-std2-3-completion-measurement — 30 min · complete before self-assessment

Standard 2.4 **NON-NEGOTIABLE** · *Standard 2: Preventive Care & Screening*

Shared Decision-Making Happens for Screening With Genuine Tradeoffs

ASSESSMENT ASF-PHC-STD2-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

2.4
NON-NEGOTIABLE
L1

THE STANDARD

Shared Decision-Making Happens for Screening With Genuine Tradeoffs

For preventive services carrying genuine, documented tradeoffs between benefit and harm — such as lung cancer screening — the practice conducts real shared decision-making with the patient, not presenting the service as an automatic, default recommendation identical to lower-tradeoff screenings.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the practice conduct genuine shared decision-making for screenings with real, documented tradeoffs?** *A real, substantive conversation, not the service presented as an automatic default.* Doc: Shared decision-making documentation	YES	PARTIAL	NO
2	**Does this conversation genuinely convey both potential benefits and potential harms, not benefits alone?** *Balanced, honest information, not a one-sided presentation favoring screening.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Can a patient who underwent such screening explain back the genuine tradeoffs they were told about?** *Tests genuine understanding, not just that a conversation technically occurred.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Shared decision-making documentation review*	Reviews records for genuine shared decision-making conversations for high-tradeoff screenings.
OBSERVE *Balanced information observation*	Observes whether the conversation genuinely conveys both benefits and harms.
ASK *Patient understanding check*	Asks a patient who underwent such screening to explain back the tradeoffs they were told about.

REFERENCES

[9] Established evidence-graded preventive service guidance recommends annual lung cancer screening for eligible patients based on sufficient evidence of net benefit, while specifically requiring a thorough process of informed and shared decision-making prior to screening given the genuine tradeoffs between benefits and harms involved.

Standard 2.4 · *Standard 2: Preventive Care & Screening*

Guidance & Learning

GUIDANCE ASF-PHC-STD2-v3.0

WHY THIS STANDARD EXISTS

Not every recommended preventive service carries the same balance of benefit and harm, and treating a service with genuine tradeoffs as an automatic default — rather than a decision the patient makes with real understanding of both sides — risks patients undergoing screening without accurately understanding what they're actually agreeing to.

The evidence: [9] Established evidence-graded preventive service guidance recommends annual lung cancer screening for eligible patients based on sufficient evidence of net benefit, while specifically requiring a thorough process of informed and shared decision-making prior to screening given the genuine tradeoffs between benefits and harms involved.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Genuine shared decision-making occurs for screenings with real, documented tradeoffs. ✓ The conversation honestly conveys both benefits and harms, not benefits alone. ✓ Patients can explain back the genuine tradeoffs in their own words.	✗ High-tradeoff screenings are presented as automatic defaults, without genuine discussion. ✗ Conversations emphasize benefits without honestly conveying potential harms. ✗ Patients cannot describe any tradeoffs, suggesting the conversation didn't genuinely happen.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Shared decision-making happens for the most well-known high-tradeoff screening but not consistently for others carrying similar genuine tradeoffs.**
Every screening with genuine tradeoffs deserves the same substantive conversation, not only the most familiar example.

2 **The conversation covers benefits thoroughly but harms are mentioned only briefly.**
Genuine shared decision-making requires honest, balanced weight given to both sides.

3 **Documentation shows the conversation occurred but doesn't capture what the patient actually understood.**
Documentation of occurrence isn't the same as evidence of genuine understanding.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine shared decision-making versus automatic default screening.

Week 2 Build a structured shared decision-making conversation covering honest benefit and harm information.

Week 3 Establish documentation capturing genuine patient understanding, not just conversation occurrence.

Ongoing Spot-check patient understanding after shared decision-making conversations.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient who underwent a high-tradeoff screening what they remember being told about potential harms.
This tests genuine understanding, not just that a conversation occurred.

Compare how thoroughly harms are discussed relative to benefits in actual documentation.
This reveals whether the conversation is genuinely balanced or benefit-weighted.

E-LEARNING academy.gmj.ge/phc-std2-4-shared-decision-making — 30 min · complete before self-assessment

	Standard 2.5 **NON-NEGOTIABLE** · *Standard 2: Preventive Care & Screening* **Immunization Status Is Actively Tracked and Gaps Are Closed**	**ASSESSMENT** ASF-PHC-STD2-v3.0

CR FULL	**TR** FULL	**SM** FULL	**ST** FULL

2.5
NON-NEGOTIABLE
L1

THE STANDARD

Immunization Status Is Actively Tracked and Gaps Are Closed

Every patient's immunization status is actively tracked against the current recommended schedule, with any identified gap actively addressed — not assumed current because no concern was raised, or left to the patient to remember and request.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is immunization status actively tracked against the current recommended schedule for every patient?** *Real, active tracking, not an assumption of currency without verification.* Doc: Immunization tracking record	YES	PARTIAL	NO
2	**Is an identified gap actively addressed, not just noted and left for the patient to raise?** *Genuine, active follow-through, not passive documentation of a known gap.* Doc: Gap closure record	YES	PARTIAL	NO
3	**Is tracking checked at any visit, not only during a visit specifically scheduled for immunization?** *An active check at any opportunity, not limited to a narrow visit type.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Tracking system review*	Reviews the immunization tracking system for genuine, active currency checking.
DOCUMENT *Gap closure review*	Reviews evidence that identified gaps are actively addressed, not just documented.
OBSERVE *Visit-type coverage observation*	Observes whether immunization status is checked across different visit types, not only dedicated immunization visits.

REFERENCES

[10] Systematic immunization tracking against current recommended schedules, with active identification and closure of gaps, is established practice in primary care preventive medicine, distinct from reliance on unprompted patient request or assumed currency.

Standard 2.5 · *Standard 2: Preventive Care & Screening*

Guidance & Learning

GUIDANCE ASF-PHC-STD2-v3.0

WHY THIS STANDARD EXISTS

An immunization gap that goes unnoticed provides no protection at all, and unlike many preventive services, immunization gaps compound risk not just for the individual patient but for the wider community — active tracking and closure is what actually catches a gap in time to matter.

The evidence: [10] Systematic immunization tracking against current recommended schedules, with active identification and closure of gaps, is established practice in primary care preventive medicine, distinct from reliance on unprompted patient request or assumed currency.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Immunization status is actively, genuinely tracked for every patient.	✗ Immunization currency is assumed without active verification.
✓ Identified gaps are actively addressed, not just documented.	✗ Gaps are noted but not actively followed through to closure.
✓ Status is checked across any visit type, not only dedicated immunization visits.	✗ Status is checked only during specifically scheduled immunization visits.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Tracking happens reliably for childhood immunizations but less consistently for adult boosters and updates.**
Adult immunization schedules carry genuine, real importance too, not only childhood series.

2 **Gaps are identified but follow-through to actually close them isn't consistently tracked to completion.**
An identified gap that isn't closed provides no more protection than one never noticed.

3 **Status is checked during well-visits but not during acute or urgent encounters.**
Any visit is a genuine opportunity to catch and address an overdue gap.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current immunization tracking practice across all age groups and visit types.

Week 2 Establish active tracking extending to adult immunizations, not only childhood series.

Week 3 Build a gap closure process tracked through to actual completion.

Ongoing Audit gap identification and closure rates periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask whether immunization status is checked during an acute or urgent visit specifically.
This is where verification most commonly lapses relative to dedicated well-visits.

Ask for a real example of an identified gap and how it was actually closed.
A real example reveals whether gap closure is genuine practice, not just identification.

E-LEARNING academy.gmj.ge/phc-std2-5-immunization-tracking — 30 min · complete before self-assessment

STANDARD 3

Chronic Disease Management

MANDATORY

5 criteria

	Standard 3.1 **NON-NEGOTIABLE** · *Standard 3: Chronic Disease Management* **Chronic Conditions Are Tracked in a Registry, Not Managed Only at the Point of Visit**	**ASSESSMENT** ASF-PHC-STD3-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

3.1
NON-NEGOTIABLE
L1

THE STANDARD

Chronic Conditions Are Tracked in a Registry, Not Managed Only at the Point of Visit

Every patient with a chronic condition — diabetes, hypertension, and other ongoing conditions — is entered into an active disease registry that tracks their status between visits, not managed only reactively during whatever visit happens to occur.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is every patient with a chronic condition entered into an active registry tracking their status?** *A real, maintained registry, not management limited to whatever happens to come up during a visit.* Doc: Chronic disease registry documentation	YES	PARTIAL	NO
2	**Does the registry track status between visits, not only reflect data from the most recent encounter?** *Genuine, ongoing tracking, not a static snapshot from the last visit alone.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is the registry actively used to inform care, not maintained as a record separate from actual practice?** *Real, integrated use, not documentation disconnected from real clinical decisions.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Registry completeness review*	Reviews the registry for genuine, complete coverage of all patients with chronic conditions.
DOCUMENT *Between-visit tracking review*	Reviews whether the registry genuinely tracks status between visits, not only at the point of care.
OBSERVE *Registry use observation*	Observes whether the registry is genuinely consulted and used to inform actual care decisions.

REFERENCES

[11] Patients with diabetes require access to systematic and ongoing care delivered by a team of healthcare providers, with registry-based tracking established as foundational to achieving national quality benchmarks for chronic disease control in primary care.

Standard 3.1 · *Standard 3: Chronic Disease Management*

Guidance & Learning

GUIDANCE ASF-PHC-STD3-v3.0

WHY THIS STANDARD EXISTS

Chronic disease outcomes depend on consistent, ongoing management over years, not just what happens to get addressed during an individual visit, and a registry is what allows the practice to actually know its full population of chronic disease patients and their real status — without it, a patient who simply doesn't come in for a while can silently fall out of active management entirely.

The evidence: [11] Patients with diabetes require access to systematic and ongoing care delivered by a team of healthcare providers, with registry-based tracking established as foundational to achieving national quality benchmarks for chronic disease control in primary care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every chronic disease patient is genuinely entered into an active registry.	✗ Chronic conditions are managed only reactively during whatever visit occurs.
✓ The registry tracks status between visits, not only at the point of care.	✗ The registry reflects only the most recent visit, with no between-visit tracking.
✓ The registry is genuinely used to inform real care decisions.	✗ A registry exists but isn't genuinely consulted in actual practice.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The registry covers diabetes and hypertension well but less consistently other chronic conditions.**
Every genuine chronic condition benefits from the same systematic tracking discipline.

2 **Registry entry happens at diagnosis but isn't consistently maintained as a patient's status changes.**
A registry needs to reflect a patient's current, real status to provide genuine ongoing value.

3 **The registry exists and is accurate but is reviewed only during scheduled chronic-care visits, not more broadly.**
Registry data has real value beyond the specific visit it was originally tied to.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current chronic disease management for reliance on point-of-visit care versus registry tracking.

Week 2 Build or strengthen a registry covering all patients with chronic conditions.

Week 3 Establish a process for keeping registry status genuinely current between visits.

Ongoing Integrate registry consultation into standard clinical workflow.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual registry and confirm it reflects genuinely current patient status.
A specific, current registry reveals genuine practice, not documentation for its own sake.

Ask a clinician how they'd identify all their patients with a specific chronic condition.
A specific, confident answer reveals genuine registry use, not reliance on memory.

E-LEARNING academy.gmj.ge/phc-std3-1-chronic-disease-registry — 30 min · complete before self-assessment

	Standard 3.2 **NON-NEGOTIABLE** · *Standard 3: Chronic Disease Management* **Control Targets Are Specific and Actively Measured, Not Assumed From General Improvement**	**ASSESSMENT** ASF-PHC-STD3-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.2
NON-NEGOTIABLE
L1

THE STANDARD

Control Targets Are Specific and Actively Measured, Not Assumed From General Improvement

Chronic disease control is measured against specific, evidence-based targets — HbA1c below 7.0 percent for diabetes, blood pressure below 130/80 mmHg for hypertension — with the actual result documented, not a general sense that a patient seems to be doing better without a specific, measured number.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is chronic disease control measured against specific, evidence-based numeric targets, not general impression?** *A specific, documented number against a defined target, not a general sense of improvement.* Doc: Control target measurement documentation	YES	PARTIAL	NO
2	**Is the actual result documented for each patient, not assumed from overall trend?** *A real, specific documented result, not an inference from general direction of change.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is the practice's own aggregate control rate calculated, not just individual results recorded without a genuine summary view?** *A real, calculated practice-level rate, not only scattered individual data points.* Doc: Aggregate control rate documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Target measurement review*	Reviews whether chronic disease control is measured against specific, evidence-based targets.
DOCUMENT *Individual result documentation review*	Reviews whether actual results are documented for individual patients, not assumed from trend.
DOCUMENT *Aggregate rate review*	Reviews whether the practice calculates its own genuine, aggregate control rate.

REFERENCES

[12] Documented national health data has found a persistent gap between the proportion of patients diagnosed with a chronic condition such as hypertension and the proportion with confirmed, documented control, establishing specific, measured control — not assumed improvement — as the genuine standard for chronic disease management quality.

Standard 3.2 · *Standard 3: Chronic Disease Management*

Guidance & Learning

GUIDANCE ASF-PHC-STD3-v3.0

WHY THIS STANDARD EXISTS

National data show real, documented gaps between actual control rates and quality benchmarks — only a portion of patients with diagnosed hypertension have genuinely documented control — and a practice that doesn't measure against specific targets has no reliable way of knowing whether its patients are actually achieving control or simply seem improved without a real, confirmed number.

The evidence: [12] Documented national health data has found a persistent gap between the proportion of patients diagnosed with a chronic condition such as hypertension and the proportion with confirmed, documented control, establishing specific, measured control — not assumed improvement — as the genuine standard for chronic disease management quality.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Control is measured against specific, evidence-based numeric targets.	✗ Improvement is assumed generally, without specific, measured targets.
✓ Actual results are documented for each patient, not assumed from trend.	✗ Results aren't documented, relying on general impression alone.
✓ The practice calculates its own genuine, aggregate control rate.	✗ No aggregate rate is calculated; only scattered individual data exists.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Targets are used for diabetes but not consistently for hypertension or other chronic conditions.**
Every chronic condition with an established target deserves the same measurement discipline.

2 **Individual results are documented but aren't consistently checked against the specific target at each visit.**
A documented result that isn't compared against the target doesn't provide genuine, actionable information.

3 **Aggregate rates are calculated periodically but not reviewed often enough to drive real, timely improvement.**
Infrequent review limits how quickly a genuine gap in control translates into real corrective action.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current chronic disease measurement for reliance on general impression versus specific targets.

Week 2 Establish consistent documentation of actual results against defined targets for every chronic condition.

Week 3 Build a process for calculating and reviewing the practice's own aggregate control rate.

Ongoing Review aggregate control rates on a regular schedule to drive genuine improvement.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the practice's actual, current aggregate control rate for a specific chronic condition.
A specific, real number reveals genuine measurement, not general impression.

Ask to see a specific patient's documented result compared against the defined target.
A real, specific comparison reveals whether measurement genuinely happens, not just data recording.

E-LEARNING academy.gmj.ge/phc-std3-2-control-target-measurement — 30 min · complete before self-assessment

Standard 3.3 **NON-NEGOTIABLE** · *Standard 3: Chronic Disease Management*

Patients Overdue for Chronic Disease Follow-Up Are Proactively Identified and Contacted

ASSESSMENT ASF-PHC-STD3-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

3.3
NON-NEGOTIABLE
L1

THE STANDARD

Patients Overdue for Chronic Disease Follow-Up Are Proactively Identified and Contacted

The practice proactively identifies patients with a chronic condition who are overdue for testing or follow-up — particularly those with poor control — and actively reaches out to them, not waiting passively for the patient to schedule their own next visit.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the practice proactively identify patients with a chronic condition who are overdue for testing or follow-up?** *Real, active identification, not passive awareness that some patients may be overdue.* Doc: Overdue patient identification process	YES	PARTIAL	NO
2	**Is there a specific, active outreach process for these patients, not just identification without follow-through?** *Genuine outreach, not identification that doesn't lead to real contact.* Doc: Outreach record	YES	PARTIAL	NO
3	**Are patients with poor control specifically prioritized in this outreach, not treated the same as those with good control?** *Genuine prioritization of the highest-risk patients, not undifferentiated outreach.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Overdue identification process review*	Reviews the specific process for identifying patients overdue for chronic disease follow-up.
DOCUMENT *Outreach record review*	Reviews evidence of genuine, active outreach to identified overdue patients.
DOCUMENT *Prioritization review*	Reviews whether patients with poor control are specifically prioritized in outreach efforts.

REFERENCES

[13] Established diabetes quality improvement practice specifically includes a process to identify and proactively reach out to patients with poor glycemic control who have not had a test in more than four months, rather than waiting for the patient to independently schedule follow-up.

Standard 3.3 · *Standard 3: Chronic Disease Management*

Guidance & Learning

GUIDANCE ASF-PHC-STD3-v3.0

WHY THIS STANDARD EXISTS

A patient with poorly controlled diabetes who simply doesn't return for a while represents genuine, real risk that compounds silently, and waiting passively for that patient to reach out themselves means the practice only reconnects with exactly the patients least likely to do so on their own.

The evidence: [13] Established diabetes quality improvement practice specifically includes a process to identify and proactively reach out to patients with poor glycemic control who have not had a test in more than four months, rather than waiting for the patient to independently schedule follow-up.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Overdue patients are genuinely, actively identified through a real process.	✗ The practice waits passively for overdue patients to schedule their own visit.
✓ Active outreach genuinely follows identification, not just passive awareness.	✗ Identification happens but doesn't lead to genuine outreach.
✓ Patients with poor control are specifically prioritized in outreach.	✗ Outreach, if it happens, doesn't prioritize the highest-risk patients.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Outreach happens for diabetes but not consistently for other chronic conditions with similar follow-up needs.**
Every chronic condition with a real follow-up requirement benefits from the same proactive discipline.

2 **Identification happens but outreach attempts aren't tracked to confirm the patient was actually reached.**
An outreach attempt that doesn't confirm actual contact provides limited real protective value.

3 **Outreach happens once but isn't repeated if the initial attempt doesn't succeed.**
A single missed attempt shouldn't end outreach for a genuinely high-risk overdue patient.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current follow-up practice for reliance on patient-initiated scheduling versus proactive outreach.

Week 2 Establish a systematic process for identifying overdue chronic disease patients.

Week 3 Build an active outreach process prioritizing patients with poor control.

Ongoing Track outreach attempts and successful contact rates.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, recent example of a patient identified as overdue and how outreach actually happened.
A real example reveals whether this is genuine practice, not just policy language.

Ask how outreach differs for a patient with poor control versus one with good control.
A specific, thoughtful answer reveals genuine prioritization, not undifferentiated practice.

E-LEARNING academy.gmj.ge/phc-std3-3-proactive-outreach — 30 min · complete before self-assessment

	Standard 3.4 **CORE** · *Standard 3: Chronic Disease Management* **Team-Based Care Coordinates Chronic Disease Management**	**ASSESSMENT** ASF-PHC-STD3-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

3.4
CORE
L1

THE STANDARD

Team-Based Care Coordinates Chronic Disease Management

Chronic disease management genuinely involves the full care team — nurses, pharmacists, or other appropriate team members, not the physician alone — with real, coordinated roles, not the physician bearing the entire ongoing management burden without support.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does chronic disease management genuinely involve the full care team, not the physician alone?** *Real, coordinated team involvement, not physician-only management.* Doc: Team-based care role documentation	YES	PARTIAL	NO
2	**Do team members have specific, defined roles in chronic disease management, not undefined or overlapping responsibility?** *Clear, specific role definition, not ambiguous shared responsibility that no one actually owns.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there real evidence that team-based involvement is genuinely improving control rates, not just present without measurable effect?** *Genuine, measurable impact, not team involvement without demonstrated benefit.* Doc: Team-based care outcome evidence	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Team involvement observation*	Observes actual chronic disease management for genuine team member involvement, not physician-only care.
DOCUMENT *Role definition review*	Reviews whether team members have specific, clearly defined roles in chronic disease management.
DOCUMENT *Outcome evidence review*	Reviews evidence connecting team-based involvement to genuine control rate improvement.

REFERENCES

[14] Meta-analysis of team-based chronic disease care found that compared with usual care, team-based approaches involving patients, primary care providers, and additional healthcare professionals such as nurses or pharmacists were associated with greater reductions in blood glucose levels and greater improvements in blood pressure and lipid control.

Standard 3.4 · *Standard 3: Chronic Disease Management*

Guidance & Learning

GUIDANCE ASF-PHC-STD3-v3.0

WHY THIS STANDARD EXISTS

Research shows team-based chronic disease care, including pharmacist involvement, measurably improves blood glucose and blood pressure control compared with physician-only management, and a practice that doesn't genuinely use its full team is both less effective for patients and places an unsustainable burden on the physician alone.

The evidence: [14] Meta-analysis of team-based chronic disease care found that compared with usual care, team-based approaches involving patients, primary care providers, and additional healthcare professionals such as nurses or pharmacists were associated with greater reductions in blood glucose levels and greater improvements in blood pressure and lipid control.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Chronic disease management genuinely involves the full care team.	✗ Chronic disease management falls entirely on the physician alone.
✓ Team members have clear, specific, defined roles.	✗ Team roles are ambiguous or overlapping, with no clear ownership.
✓ Real evidence shows team-based care is genuinely improving control rates.	✗ No evidence connects team involvement to genuine outcome improvement.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Nursing staff are genuinely involved but pharmacist expertise, where available, isn't systematically used.**
Different team members bring genuinely distinct, complementary expertise to chronic disease management.

2 **Team involvement is strong for diabetes but less developed for other chronic conditions.**
The same team-based approach benefits management of any chronic condition, not diabetes alone.

3 **Roles are defined but not consistently followed in actual daily practice.**
A defined role that isn't genuinely followed doesn't provide the real coordination benefit this approach is meant to offer.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current chronic disease management for genuine team involvement versus physician-only care.

Week 2 Define specific, clear roles for team members in chronic disease management.

Week 3 Extend team-based involvement to chronic conditions beyond diabetes where appropriate.

Ongoing Track outcomes to confirm team-based involvement is genuinely improving control.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a nurse or other team member to describe their specific role in chronic disease management.
A specific, confident answer reveals genuine, defined involvement, not nominal team structure.

Ask how control rates have changed since team-based roles were established, if they have been.
A real, specific answer reveals genuine, measured impact.

E-LEARNING academy.gmj.ge/phc-std3-4-team-based-care — 30 min · complete before self-assessment

Standard 3.5 **NON-NEGOTIABLE** · *Standard 3: Chronic Disease Management*

Medication Adjustment Follows a Defined Process When Targets Aren't Met

ASSESSMENT ASF-PHC-STD3-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

3.5
NON-NEGOTIABLE
L1

THE STANDARD

Medication Adjustment Follows a Defined Process When Targets Aren't Met

When a patient's chronic disease control falls short of the defined target, medication or treatment adjustment follows a specific, defined process within a reasonable timeframe — not left unchanged indefinitely simply because the patient hasn't raised a concern.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does treatment adjustment follow a specific, defined process when a patient's control falls short of target?** *A real, defined process, not indefinite continuation of unchanged treatment.* Doc: Treatment adjustment protocol documentation	YES	PARTIAL	NO
2	**Does adjustment happen within a reasonable, defined timeframe, not delayed indefinitely?** *A specific, genuine timeframe, not an open-ended delay.* Doc: Adjustment timing record	YES	PARTIAL	NO
3	**Is there defined follow-up after a treatment adjustment to confirm it's actually working?** *Real, scheduled follow-up, not an adjustment made without checking whether it succeeded.* Doc: Post-adjustment follow-up record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Adjustment protocol review*	Reviews the specific, defined process for treatment adjustment when targets aren't met.
DOCUMENT *Adjustment timing review*	Reviews records for a sample of patients with poor control to confirm adjustment happens within a reasonable timeframe.
DOCUMENT *Follow-up after adjustment review*	Reviews whether defined follow-up occurs after a treatment adjustment to confirm effectiveness.

REFERENCES

[15] A hypertension management program that included evidence-based practice guidelines for pharmacological treatment adjustment and defined follow-up after medication changes was associated with measurably improved hypertension control rates, establishing a defined adjustment process, distinct from unchanged treatment, as genuinely effective practice.

Standard 3.5 · *Standard 3: Chronic Disease Management*

Guidance & Learning

GUIDANCE ASF-PHC-STD3-v3.0

WHY THIS STANDARD EXISTS

Clinical inertia — continuing an unchanged treatment despite a patient genuinely not meeting their control target — is a well-documented, real pattern that allows a patient to remain in poor control far longer than clinically necessary, simply because no one actively revisited the treatment plan.

The evidence: [15] A hypertension management program that included evidence-based practice guidelines for pharmacological treatment adjustment and defined follow-up after medication changes was associated with measurably improved hypertension control rates, establishing a defined adjustment process, distinct from unchanged treatment, as genuinely effective practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Treatment adjustment follows a specific, defined process when targets aren't met.	✗ Treatment remains unchanged indefinitely despite a patient not meeting target.
✓ Adjustment happens within a genuine, reasonable timeframe.	✗ Adjustment, when it happens, is significantly delayed with no defined timeframe.
✓ Defined follow-up confirms whether an adjustment actually worked.	✗ No follow-up confirms whether an adjustment succeeded.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Adjustment happens reliably for patients seen regularly but less consistently for those with sporadic visit patterns.**
A patient with sporadic visits still deserves genuine, timely treatment adjustment when control is poor.

2 **A defined process exists but isn't consistently followed when the clinician feels a patient's situation is 'close enough' to target.**
A defined target deserves consistent application, not informal discretion about what counts as close enough.

3 **Adjustments are made but follow-up to confirm effectiveness happens inconsistently.**

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current treatment adjustment practice for evidence of clinical inertia.

Week 2 Establish a specific, defined adjustment protocol with a genuine timeframe.

Week 3 Build defined follow-up after every treatment adjustment.

Ongoing Audit adjustment timing and follow-up completion for patients with poor control.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, specific example of a patient whose treatment was adjusted after not meeting target.
A real, traceable example reveals whether adjustment genuinely happens promptly, not just in policy.

Ask what happens if a scheduled follow-up after adjustment doesn't occur.
A specific, confident answer reveals genuine tracking, not an assumption follow-up will happen.

E-LEARNING academy.gmj.ge/phc-std3-5-treatment-adjustment — 30 min · complete before self-assessment

STANDARD 4

Acute & Same-Day Care

MANDATORY

5 criteria

	Standard 4.1 NON-NEGOTIABLE · *Standard 4: Acute & Same-Day Care* **Red Flag Symptoms Are Actively Screened at Intake, Not Only by the Clinician Later**	ASSESSMENT ASF-PHC-STD4-v3.0
CR FULL	TR FULL	SM ADAPTED / ST FULL

4.1
NON-NEGOTIABLE
L1

THE STANDARD

Red Flag Symptoms Are Actively Screened at Intake, Not Only by the Clinician Later

Staff performing patient intake and registration — not only the treating clinician — are trained to recognise defined red flag symptoms and immediately escalate, with a specific process for taking the patient back for urgent assessment right away, not left waiting in a normal queue.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are staff performing intake and registration specifically trained to recognise defined red flag symptoms?** *Genuine, specific training for intake staff, not a responsibility left only to the clinician.* Doc: Intake staff red flag training record	YES	PARTIAL	NO
2	**Is there a specific, immediate escalation process when a red flag is recognised at intake?** *A real, immediate process, not a patient left in the normal queue despite a recognised red flag.* Doc: Red flag escalation protocol	YES	PARTIAL	NO
3	**Is there a specific, ready space for a patient identified with a potential emergency at intake?** *A real, dedicated, ready space, not an improvised response when a red flag is identified.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Intake training review*	Reviews training records confirming intake staff are specifically trained on defined red flags.
ASK *Recognition and escalation interview*	Asks an intake staff member to describe specific red flags and what they'd do if one were identified.
OBSERVE *Ready space check*	Confirms a specific space is genuinely ready for an emergency identified at intake.

REFERENCES

[16] Established urgent care red flag policy requires that staff responsible for patient intake, not only the treating provider, be able to recognise defined red flag signs and symptoms and immediately take the patient to a space kept ready for emergencies, so there is no delay in care.

Standard 4.1 · *Standard 4: Acute & Same-Day Care*

Guidance & Learning

GUIDANCE ASF-PHC-STD4-v3.0

WHY THIS STANDARD EXISTS

The person a patient first speaks to is often not the clinician, and a genuinely serious symptom recognised only once the clinician eventually sees the patient has already lost real time that could matter — training intake staff to recognise defined red flags is what closes this gap at the earliest possible point.

The evidence: [16] Established urgent care red flag policy requires that staff responsible for patient intake, not only the treating provider, be able to recognise defined red flag signs and symptoms and immediately take the patient to a space kept ready for emergencies, so there is no delay in care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Intake staff are specifically, genuinely trained to recognise defined red flags.	✗ Red flag recognition is left entirely to the clinician, not intake staff.
✓ A specific, immediate escalation process exists and is followed.	✗ No specific, immediate escalation process exists beyond the normal queue.
✓ A dedicated space is genuinely ready for a patient identified with a potential emergency.	✗ No dedicated space is genuinely ready when a red flag is identified.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Training happened once at hiring but hasn't been refreshed or reinforced since.**
Red flag recognition is a skill that benefits from genuine, periodic reinforcement, not a single training session.

2 **Escalation happens for the most obvious red flags but staff are less confident with subtler ones.**
The genuine protective value of this training depends on covering the full defined list, not only the most obvious signs.

3 **A ready space exists but is sometimes occupied, without a clear, defined alternative.**
A real, defined alternative for exactly this situation is what makes the process genuinely reliable.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current intake practice for genuine red flag recognition training.

Week 2 Train intake staff specifically on the defined red flag list and escalation process.

Week 3 Establish or confirm a ready space, with a defined alternative if it's occupied.

Ongoing Refresh intake staff training on red flag recognition periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask an intake or registration staff member directly to name a specific red flag and what they'd do.
A specific, confident answer reveals genuine training, not assumed general awareness.

Ask what happens if the dedicated emergency space is already occupied.
A specific, confident answer reveals a genuinely thought-through process, not an assumption it won't happen.

E-LEARNING academy.gmj.ge/phc-std4-1-intake-red-flags — 30 min · complete before self-assessment

	Standard 4.2 **NON-NEGOTIABLE** · *Standard 4: Acute & Same-Day Care* **Same-Day Access Is Genuinely Available, Not Assumed Adequate Without Measurement**	**ASSESSMENT** ASF-PHC-STD4-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

4.2
NON-NEGOTIABLE
L1

THE STANDARD

Same-Day Access Is Genuinely Available, Not Assumed Adequate Without Measurement

The practice actively measures whether patients requesting a genuine same-day need can actually be seen that day, with a specific, tracked target — not an assumption that same-day access is adequate without ever checking real appointment availability against real demand.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the practice actively measure whether genuine same-day requests are actually accommodated that day?** *Real, calculated measurement, not an assumption of adequacy.* Doc: Same-day access measurement record	YES	PARTIAL	NO
2	**Is there a specific, defined target for same-day access, not a vague sense that most patients get seen?** *A specific, tracked target, not an undefined general impression.* Doc: Same-day access target documentation	YES	PARTIAL	NO
3	**When same-day access falls short of target, is there a genuine response, not a measure tracked without consequence?** *Real, active response to a shortfall, not passive tracking alone.* Doc: Access shortfall response record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Access measurement review*	Reviews whether the practice genuinely measures same-day access against actual demand.
DOCUMENT *Target definition review*	Reviews whether a specific, defined same-day access target exists.
DOCUMENT *Shortfall response review*	Reviews evidence of genuine response when same-day access falls short.

REFERENCES

[17] A substantial majority of primary and urgent care activity in many health systems consists of patients requesting same-day services, establishing genuine same-day access as a core, high-volume function of primary care requiring active measurement, not passive assumption of adequacy.

Standard 4.2 · *Standard 4: Acute & Same-Day Care*

Guidance & Learning

GUIDANCE ASF-PHC-STD4-v3.0

WHY THIS STANDARD EXISTS

Same-day requests represent a substantial majority of primary care activity, and a practice that doesn't measure its own actual same-day availability against real demand has no reliable way of knowing whether patients with a genuine same-day need are actually being accommodated, or are being pushed to a later date, an emergency department, or simply going without care.

The evidence: [17] A substantial majority of primary and urgent care activity in many health systems consists of patients requesting same-day services, establishing genuine same-day access as a core, high-volume function of primary care requiring active measurement, not passive assumption of adequacy.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Same-day access is genuinely, actively measured against real demand.	✗ Same-day access adequacy is assumed without genuine measurement.
✓ A specific, defined target exists and is tracked.	✗ No specific target exists; adequacy is judged by general impression.
✓ A genuine response follows when access falls short of target.	✗ Shortfalls, if identified, produce no genuine response.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Measurement happens but doesn't distinguish genuine same-day medical need from lower-urgency requests.**
Genuine measurement needs to reflect real clinical urgency, not treat all same-day requests identically.

2 **A target exists but hasn't been reviewed to confirm it's actually appropriate for this practice's real patient volume.**
A target should genuinely reflect this practice's own circumstances, not an arbitrary figure.

3 **Shortfalls are identified but the response addresses only the immediate day, not underlying causes.**
Genuine improvement requires understanding why access falls short, not only reacting to individual days.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current same-day access practice for genuine measurement versus assumed adequacy.

Week 2 Establish a specific, defined same-day access target appropriate to this practice.

Week 3 Build a genuine response process for identified shortfalls, addressing underlying causes.

Ongoing Track same-day access against target on a regular schedule.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the practice's actual, current same-day access rate, not a general impression.
A specific, real number reveals genuine measurement, not an assumption.

Ask what happened the last time same-day access genuinely fell short of target.
A real example reveals whether measurement leads to real action.

E-LEARNING academy.gmj.ge/phc-std4-2-same-day-access — 30 min · complete before self-assessment

Standard 4.3 **NON-NEGOTIABLE** · *Standard 4: Acute & Same-Day Care*

Telephone or Remote Triage Follows a Structured, Validated Protocol

ASSESSMENT ASF-PHC-STD4-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

4.3
NON-NEGOTIABLE
L1

THE STANDARD

Telephone or Remote Triage Follows a Structured, Validated Protocol

Telephone or remote triage of patients requesting same-day care follows a structured, validated protocol — not the individual judgement of whoever happens to answer the phone, applied inconsistently from one call to the next.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Does telephone or remote triage follow a structured, validated protocol, not individual judgement alone?** *A real, structured protocol, not inconsistent practice dependent on who answers the call.* Doc: Triage protocol documentation	YES	PARTIAL	NO
2	**Is the protocol consistently used across different staff members conducting triage?** *Genuine, consistent application, not a protocol used by some staff but not others.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does the protocol specifically prompt for red flag symptoms, not rely on the patient volunteering concerning details?** *Active, structured questioning for red flags, not passive reliance on what the patient happens to mention.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Protocol documentation review*	Reviews the actual, structured triage protocol used for same-day requests.
OBSERVE *Consistency observation*	Observes or reviews records for consistent protocol use across different staff members.
DOCUMENT *Red flag prompting review*	Reviews whether the protocol actively prompts for red flag symptoms.

REFERENCES

[18] Structured telephone triage protocols for patients requesting same-day primary care appointments are established, evidence-based practice, distinct from unstructured individual judgement, with research demonstrating their effectiveness in managing primary care workload while maintaining patient safety.

Standard 4.3 · *Standard 4: Acute & Same-Day Care*

Guidance & Learning

GUIDANCE ASF-PHC-STD4-v3.0

WHY THIS STANDARD EXISTS

Telephone triage carries genuine, real risk of missed or delayed recognition of a serious condition specifically because the person triaging can't see the patient, and a structured, validated protocol is what closes this gap by ensuring the same, evidence-based questions are asked consistently, rather than depending entirely on the individual judgement and experience of whoever answers a specific call.

The evidence: [18] Structured telephone triage protocols for patients requesting same-day primary care appointments are established, evidence-based practice, distinct from unstructured individual judgement, with research demonstrating their effectiveness in managing primary care workload while maintaining patient safety.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Triage genuinely follows a structured, validated protocol.	✗ Triage depends on individual judgement, applied inconsistently.
✓ The protocol is consistently used across all staff conducting triage.	✗ Protocol use varies significantly between different staff members.
✓ The protocol actively prompts for red flag symptoms, not passive reliance on patient disclosure.	✗ Red flag identification relies on the patient volunteering concerning details unprompted.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The protocol is used consistently by experienced staff but less reliably by newer team members.**
A structured protocol needs to be genuinely reliable regardless of individual staff experience level.

2 **The protocol covers common presentations well but is less developed for less typical symptom patterns.**
Less common presentations still carry real risk and deserve the same structured approach.

3 **Red flag prompting happens but isn't consistently documented, making genuine adherence hard to verify.**
Undocumented adherence is difficult to distinguish from a protocol not genuinely followed.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current telephone triage practice for structured protocol use versus individual judgement.

Week 2 Establish or strengthen a structured, validated triage protocol.

Week 3 Train all staff conducting triage on consistent protocol use.

Ongoing Audit triage documentation for genuine, consistent protocol adherence.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual triage protocol document, not a general description of practice.
A specific, real protocol reveals genuine structure, not assumed consistency.

Ask a newer staff member to walk through the triage protocol for a specific presentation.
This tests whether the protocol genuinely reaches all staff, not only the most experienced.

E-LEARNING academy.gmj.ge/phc-std4-3-structured-triage — 30 min · complete before self-assessment

Standard 4.4 **NON-NEGOTIABLE** · *Standard 4: Acute & Same-Day Care*

Atypical Presentations Receive Genuine Consideration, Not Dismissed as Benign by Default

ASSESSMENT ASF-PHC-STD4-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

4.4
NON-NEGOTIABLE
L1

THE STANDARD

Atypical Presentations Receive Genuine Consideration, Not Dismissed as Benign by Default

When a patient's presentation is atypical or overlaps with a benign condition, the clinician genuinely considers serious alternative diagnoses before defaulting to a benign explanation — not treating overlap with common, self-limiting illness as sufficient reason to rule out something more serious.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the clinician genuinely consider serious alternative diagnoses for an atypical or overlapping presentation?** *Real, active consideration, not immediate default to the more common, benign explanation.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is there a specific process for documenting why a serious alternative was considered and ruled out?** *A real, documented reasoning process, not an assumption reflected only in the final diagnosis.* Doc: Diagnostic reasoning documentation	YES	PARTIAL	NO
3	**Is there a defined safety-net process — return advice, follow-up — for a patient whose presentation remains uncertain?** *A real, defined safety-net, not the patient sent away with no clear guidance if symptoms don't resolve as expected.* Doc: Safety-net advice protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

OBSERVE *Diagnostic reasoning observation*	Observes an actual consultation for genuine consideration of serious alternatives, not default assumption.
DOCUMENT *Reasoning documentation review*	Reviews documentation for evidence that serious alternatives were genuinely considered and ruled out.
DOCUMENT *Safety-net protocol review*	Reviews the defined safety-net process for patients with uncertain presentations.

REFERENCES

[19] Structured approaches to red flag identification are established as necessary in primary care because a substantial number of serious conditions present with atypical or nonspecific symptoms resembling benign, self-limiting illness, requiring genuine differentiation rather than default assumption of the more common explanation.

Standard 4.4 · *Standard 4: Acute & Same-Day Care*

Guidance & Learning

GUIDANCE ASF-PHC-STD4-v3.0

WHY THIS STANDARD EXISTS

A substantial share of serious conditions genuinely present with symptoms that closely resemble common, benign illness, and defaulting to the more common explanation without genuinely considering red flags or atypical features is a well-documented, real pattern behind missed or delayed diagnosis in primary care specifically.

The evidence: [19] Structured approaches to red flag identification are established as necessary in primary care because a substantial number of serious conditions present with atypical or nonspecific symptoms resembling benign, self-limiting illness, requiring genuine differentiation rather than default assumption of the more common explanation.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Serious alternative diagnoses are genuinely, actively considered for atypical presentations.	✗ Overlap with a common, benign condition is treated as sufficient to rule out something more serious.
✓ Diagnostic reasoning, including ruled-out alternatives, is genuinely documented.	✗ Diagnostic reasoning isn't documented beyond the final diagnosis reached.
✓ A defined safety-net process exists for uncertain presentations.	✗ No defined safety-net exists for a patient whose presentation remains uncertain.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Consideration of serious alternatives is genuine for well-known atypical presentations but less consistent for rarer ones.**
Every genuinely atypical presentation deserves the same careful consideration, not only the most well-known examples.

2 **Safety-net advice is given verbally but not consistently documented or reinforced in writing.**
Documented, reinforced safety-net advice is more reliable than a verbal mention alone.

3 **Reasoning is documented for complex cases but less consistently for presentations that seem straightforward.**
A presentation that seems straightforward can still benefit from the same documented reasoning discipline.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current diagnostic practice for genuine consideration of serious alternatives in atypical presentations.

Week 2 Train staff on documenting diagnostic reasoning, including alternatives considered and ruled out.

Week 3 Establish a defined, consistently applied safety-net advice process.

Ongoing Review cases with uncertain presentations for genuine adherence to safety-net practice.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a clinician to walk through their reasoning for a real, recent atypical presentation.
A specific, thoughtful answer reveals genuine consideration, not default assumption.

Ask what safety-net advice a patient with an uncertain presentation actually received.
A specific, real answer reveals whether this is genuine practice, not just policy language.

E-LEARNING academy.gmj.ge/phc-std4-4-atypical-presentation-safety — 30 min · complete before self-assessment

	Standard 4.5 **CORE** · *Standard 4: Acute & Same-Day Care* **A Dedicated, Ready Emergency Response Exists for a Deteriorating Patient**	**ASSESSMENT** ASF-PHC-STD4-v3.0

CR FULL	TR FULL	SM ADAPTED	ST FULL

4.5
CORE
L1

THE STANDARD

A Dedicated, Ready Emergency Response Exists for a Deteriorating Patient

The practice maintains a specific, dedicated process and space for a patient who deteriorates or presents in genuine crisis while at the clinic — emergency equipment checked and ready, staff roles defined, a clear pathway to emergency services — not an improvised response assembled in the moment.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is there a specific, dedicated space and process ready for a patient who deteriorates while at the clinic?** *A real, ready process, not something assembled improvised in the moment.* Doc: Emergency response protocol documentation	YES	PARTIAL	NO
2	**Is emergency equipment genuinely checked and ready, not assumed functional without verification?** *Real, verified readiness, not assumed equipment condition.* Doc: Equipment check record	YES	PARTIAL	NO
3	**Are staff roles specifically defined for this scenario, with a clear pathway to emergency services?** *Specific, practiced role clarity, not general awareness that an emergency plan exists somewhere.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Emergency readiness check*	Physically checks the dedicated emergency space and equipment for genuine readiness.
DOCUMENT *Equipment check record review*	Reviews records of regular equipment verification, not assumed function.
ASK *Role clarity interview*	Asks staff to describe their specific role during a genuine on-site emergency.

REFERENCES

[20] Dedicated space, ready emergency equipment, and defined staff roles for a deteriorating patient, distinct from improvised response, are established practice in urgent and primary care safety policy for managing genuine on-site emergencies.

Standard 4.5 · *Standard 4: Acute & Same-Day Care*

Guidance & Learning

GUIDANCE ASF-PHC-STD4-v3.0

WHY THIS STANDARD EXISTS

A primary care clinic, unlike a hospital, doesn't have emergency department resources immediately on hand, and a patient who genuinely deteriorates while at the clinic depends entirely on staff having a real, practiced response ready before it's needed — not figuring out roles and equipment for the first time during the actual emergency.

The evidence: [20] Dedicated space, ready emergency equipment, and defined staff roles for a deteriorating patient, distinct from improvised response, are established practice in urgent and primary care safety policy for managing genuine on-site emergencies.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, dedicated space and process are genuinely ready for a deteriorating patient.	✗ No specific process exists beyond an assumption staff would respond appropriately.
✓ Emergency equipment is genuinely checked and verified as functional.	✗ Emergency equipment condition is assumed, not verified.
✓ Staff roles are specifically defined and confidently known.	✗ Staff are uncertain about their specific role during a genuine emergency.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Equipment is present but checking happens irregularly, without a defined schedule.**
A defined, regular check schedule is what makes equipment readiness genuinely reliable.

2 **Roles are defined on paper but haven't been practiced through an actual drill.**
A rehearsed response is more reliable under real, high-pressure conditions than a plan read once.

3 **The pathway to emergency services is known by senior staff but not consistently by newer team members.**
Any staff member present during a genuine emergency needs the same confident knowledge of the pathway.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current emergency readiness for genuine, verified equipment and defined roles.

Week 2 Establish a regular equipment check schedule and confirm functional readiness.

Week 3 Brief all staff on their specific role and the pathway to emergency services.

Ongoing Conduct periodic drills to genuinely practice the emergency response.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual, current equipment check record, not a general assurance it's maintained.
A specific, real record reveals genuine verification, not assumed readiness.

Ask a newer staff member their specific role during a genuine on-site emergency.
This reveals whether readiness genuinely extends to all staff, not only the most experienced.

E-LEARNING academy.gmj.ge/phc-std4-5-emergency-readiness — 30 min · complete before self-assessment

STANDARD 5

Referral & Care Coordination

MANDATORY

5 criteria

Standard 5.1 **NON-NEGOTIABLE** · *Standard 5: Referral & Care Coordination*

Every Referral Is Tracked to Actual Completion, Not Assumed to Have Happened

ASSESSMENT ASF-PHC-STD5-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

5.1
NON-NEGOTIABLE
L1

THE STANDARD

Every Referral Is Tracked to Actual Completion, Not Assumed to Have Happened

Every specialist referral is actively tracked from the point it's sent through to a documented, completed appointment — not assumed to have happened simply because the referral was made, with no active follow-up to confirm the patient was actually seen.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is every referral actively tracked from the point it's sent through to a documented, completed appointment?** *Real, active tracking to actual completion, not assumed follow-through.* Doc: Referral tracking record	YES	PARTIAL	NO
2	**Is there a specific process for identifying a referral that hasn't resulted in a completed appointment within an expected timeframe?** *A real, active identification process, not passive hope the referral was completed.* Doc: Incomplete referral identification process	YES	PARTIAL	NO
3	**When an incomplete referral is identified, is there a genuine follow-up action, not just awareness the gap exists?** *Real, active follow-up, not a gap noted without resolution.* Doc: Follow-up action record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Tracking system review*	Reviews the referral tracking system for genuine tracking to actual completion, not assumed follow-through.
DOCUMENT *Incomplete referral identification review*	Reviews the process for identifying referrals that haven't resulted in a completed appointment.
DOCUMENT *Follow-up action review*	Reviews evidence of genuine follow-up action when an incomplete referral is identified.

REFERENCES

[21] An analysis of over 100,000 referral scheduling attempts in a large health system found only 34.8 percent resulted in documented completed specialist appointments, establishing active tracking to completion, distinct from assumed follow-through, as essential to closing the referral loop.

Standard 5.1 · *Standard 5: Referral & Care Coordination*

Guidance & Learning

GUIDANCE ASF-PHC-STD5-v3.0

WHY THIS STANDARD EXISTS

National research has found that fewer than half of specialist referrals actually result in a documented, completed appointment, and a referral sent without active tracking provides no real assurance the patient ever received the care they were referred for — the referral itself is only the first step, not the outcome.

The evidence: [21] An analysis of over 100,000 referral scheduling attempts in a large health system found only 34.8 percent resulted in documented completed specialist appointments, establishing active tracking to completion, distinct from assumed follow-through, as essential to closing the referral loop.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every referral is genuinely tracked through to documented completion.	✗ Referrals are assumed complete once sent, with no active tracking.
✓ A specific process identifies referrals that haven't completed within an expected timeframe.	✗ No process identifies referrals that have stalled or failed to complete.
✓ Genuine follow-up action resolves identified gaps, not just notes them.	✗ Incomplete referrals are recognized but not actively resolved.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Tracking exists for referrals to some specialties but not consistently across all specialty types.**
Every referral, regardless of specialty, carries the same real risk of falling through without active tracking.

2 **Incomplete referrals are identified but the expected timeframe for follow-up varies inconsistently.**
A consistent, defined timeframe is what makes identification genuinely reliable, not left to individual judgement.

3 **Follow-up happens once but isn't repeated if the initial attempt doesn't resolve the gap.**
A single follow-up attempt that doesn't succeed shouldn't end active tracking of a still-incomplete referral.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current referral practice for genuine tracking versus assumed completion.

Week 2 Establish a systematic tracking process covering every referral to actual documented completion.

Week 3 Define a specific timeframe and process for identifying incomplete referrals.

Ongoing Track referral completion rates and follow up on identified gaps until resolved.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the practice's actual, current referral completion rate, not a general impression.
A specific, real number reveals genuine tracking, not an assumption of adequacy.

Ask for a real, recent example of an incomplete referral and what happened next.
A real, traceable example reveals whether tracking genuinely leads to resolution, not just identification.

E-LEARNING academy.gmj.ge/phc-std5-1-referral-tracking — 30 min · complete before self-assessment

Standard 5.2 **NON-NEGOTIABLE** · *Standard 5: Referral & Care Coordination*

Specialist Findings Return to the Referring Clinician Within a Defined Timeframe

ASSESSMENT ASF-PHC-STD5-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

5.2
NON-NEGOTIABLE
L1

THE STANDARD

Specialist Findings Return to the Referring Clinician Within a Defined Timeframe

Specialist consultation notes and findings are returned to the referring clinician within a specific, defined timeframe, actively confirmed as received — not left to arrive whenever they happen to, or lost entirely in an unreviewed pile of incoming correspondence.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are specialist findings returned to the referring clinician within a specific, defined timeframe?** *A real, specific timeframe, not an open-ended expectation of eventual return.* Doc: Specialist return timeframe documentation	YES	PARTIAL	NO
2	**Is receipt of specialist findings actively confirmed, not assumed if nothing seems to go wrong?** *Genuine, active confirmation, not passive assumption of receipt.* Doc: Receipt confirmation record	YES	PARTIAL	NO
3	**Is there a specific process for following up when specialist findings don't arrive within the expected timeframe?** *A real, active follow-up process, not findings simply waited for indefinitely.* Doc: Missing findings follow-up process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Timeframe definition review*	Reviews whether a specific, defined timeframe exists for specialist findings to return.
DOCUMENT *Receipt confirmation review*	Reviews evidence that receipt of specialist findings is actively confirmed, not assumed.
DOCUMENT *Missing findings follow-up review*	Reviews the process for following up when findings don't arrive as expected.

REFERENCES

[22] Institute for Healthcare Improvement, National Patient Safety Foundation. Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era. Cambridge, MA: IHI; 2017 — establishes a standardized, nine-step closed-loop process requiring specialist findings to be communicated back to the referring clinician through appropriate channels within a defined timeframe.

Standard 5.2 · *Standard 5: Referral & Care Coordination*

Guidance & Learning

GUIDANCE ASF-PHC-STD5-v3.0

WHY THIS STANDARD EXISTS

A referring clinician who never receives specialist findings can't actually make informed decisions about the patient's ongoing care, and research shows this happens far more often than assumed — referring physicians commonly hear back on only a small fraction of the referrals they send, leaving genuine clinical decisions made without information that should have informed them.

The evidence: [22] Institute for Healthcare Improvement, National Patient Safety Foundation. Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era. Cambridge, MA: IHI; 2017 — establishes a standardized, nine-step closed-loop process requiring specialist findings to be communicated back to the referring clinician through appropriate channels within a defined timeframe.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A specific, defined timeframe governs when specialist findings should return.	✗ No specific timeframe exists; findings arrive whenever they happen to.
✓ Receipt is actively confirmed, not assumed.	✗ Receipt is assumed unless a problem becomes obvious.
✓ A real follow-up process addresses findings that don't arrive as expected.	✗ No follow-up occurs when expected findings don't arrive.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A timeframe exists but isn't consistently communicated to the specialist practices being referred to.**
A timeframe the specialist practice doesn't know about is unlikely to be genuinely honored.

2 **Findings that do arrive are reviewed promptly but incoming correspondence isn't systematically checked for what's missing.**
Genuine tracking requires actively noticing what hasn't arrived, not just processing what has.

3 **Follow-up happens for referrals the clinician specifically remembers but not systematically across all pending referrals.**
A systematic process, not individual clinician memory, is what makes this reliable across every referral.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for a specific, defined return timeframe for specialist findings.

Week 2 Communicate the expected timeframe to specialist practices and establish receipt confirmation.

Week 3 Build a systematic process for identifying and following up on missing findings.

Ongoing Track findings receipt against the defined timeframe.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for the specific, defined timeframe the practice expects specialist findings within.
A specific, real answer reveals a genuine standard, not an open-ended expectation.

Ask how the practice would know if specialist findings for a specific referral never arrived.
A specific, confident answer reveals genuine systematic tracking, not reliance on individual memory.

E-LEARNING academy.gmj.ge/phc-std5-2-specialist-findings-return — 30 min · complete before self-assessment

Standard 5.3 **NON-NEGOTIABLE** · *Standard 5: Referral & Care Coordination*

Responsibility for Follow-Up Is Explicitly Assigned, Not Left Ambiguous

ASSESSMENT ASF-PHC-STD5-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

5.3
NON-NEGOTIABLE
L1

THE STANDARD

Responsibility for Follow-Up Is Explicitly Assigned, Not Left Ambiguous

At every stage of the referral process, one specific person or role is explicitly responsible for the next step — not left as shared or assumed responsibility that, in practice, no one specifically owns.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is one specific person or role explicitly responsible for each stage of the referral process?** *Real, specific, named responsibility, not shared or assumed ownership.* Doc: Referral process role assignment documentation	YES	PARTIAL	NO
2	**Can any staff member correctly identify who is responsible for a specific stage, without hesitation?** *Genuine, confident, consistent knowledge, not uncertainty about who owns a given step.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**When responsibility changes — staff turnover, role changes — is the assignment genuinely updated, not left stale?** *Real, maintained assignment, not an outdated structure that no longer reflects who actually does the work.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Role assignment review*	Reviews documentation for specific, explicit responsibility assignment at each referral stage.
ASK *Responsibility identification interview*	Asks multiple staff members to identify who is responsible for a specific referral stage.
DOCUMENT *Assignment currency review*	Reviews whether responsibility assignment is genuinely updated as staff or roles change.

REFERENCES

[23] Research into primary care and specialist referral handoffs identifies ambiguous responsibility for coordinating patient care as a specific, documented area of breakdown, distinct from individual clinician failure, arising when no single role is explicitly assigned ownership of a given step.

Standard 5.3 · *Standard 5: Referral & Care Coordination*

Guidance & Learning

GUIDANCE ASF-PHC-STD5-v3.0

WHY THIS STANDARD EXISTS

Documented research into referral breakdowns specifically identifies ambiguous responsibility as a genuine, recurring cause of failure — when it's unclear exactly who is responsible for a specific step, that step is measurably more likely to simply not happen, not because anyone failed individually, but because no one specifically owned it.

The evidence: [23] Research into primary care and specialist referral handoffs identifies ambiguous responsibility for coordinating patient care as a specific, documented area of breakdown, distinct from individual clinician failure, arising when no single role is explicitly assigned ownership of a given step.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Specific, explicit responsibility is assigned at every referral stage.	✗ Responsibility is shared or assumed, with no specific ownership.
✓ Staff can confidently, consistently identify who owns each stage.	✗ Staff give inconsistent or uncertain answers about who is responsible.
✓ Assignment is genuinely kept current as staff and roles change.	✗ Assignment structure is outdated, not reflecting who actually does the work.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Responsibility is clearly assigned for the initial referral but less clear for the follow-up tracking stage.**
Every stage of the process, not only the initial step, needs the same explicit ownership.

2 **Assignment exists on paper but staff describe genuine uncertainty in daily practice.**
A documented assignment that isn't genuinely understood in practice provides limited real protection.

3 **Assignment was accurate at one point but hasn't been updated following recent staff changes.**
Stale assignment structure can leave a step effectively unowned despite appearing assigned on paper.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current referral process for genuine, specific responsibility assignment at each stage.

Week 2 Establish explicit, named ownership for every stage, including follow-up tracking.

Week 3 Brief all relevant staff on the current, specific assignment structure.

Ongoing Update assignment promptly whenever staff or roles change.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask two different staff members who is responsible for the same specific referral stage.
Consistent, confident answers reveal genuine clarity; inconsistent answers reveal ambiguity.

Ask how responsibility assignment was updated after the most recent staff change.
A specific, real answer reveals whether the structure is genuinely maintained, not left stale.

E-LEARNING academy.gmj.ge/phc-std5-3-referral-responsibility — 30 min · complete before self-assessment

Standard 5.4 **NON-NEGOTIABLE** · *Standard 5: Referral & Care Coordination*

A Genuinely Urgent Referral Is Tracked With Greater Urgency Than a Routine One

ASSESSMENT ASF-PHC-STD5-v3.0

CR N/A	TR FULL	SM FULL	ST FULL

5.4
NON-NEGOTIABLE
L1

THE STANDARD

A Genuinely Urgent Referral Is Tracked With Greater Urgency Than a Routine One

A referral for a genuinely urgent clinical concern is tracked and followed up with meaningfully greater urgency than a routine referral — not placed into the same tracking process and timeframe as any other referral, regardless of the underlying concern's real clinical significance.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is a genuinely urgent referral tracked with meaningfully greater urgency than a routine one?** *A real, differentiated process, not identical tracking regardless of clinical significance.* Doc: Urgency-differentiated tracking documentation	YES	PARTIAL	NO
2	**Is urgency specifically communicated to the receiving specialist, not left for them to infer?** *Explicit, clear urgency communication, not an assumption the specialist will recognise it independently.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific, shorter timeframe for identifying an incomplete urgent referral, distinct from routine referrals?** *A genuinely shorter, specific timeframe, not the same interval applied to every referral.* Doc: Urgent referral timeframe documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Differentiated tracking review*	Reviews whether urgent referrals genuinely receive more intensive tracking than routine ones.
OBSERVE *Urgency communication observation*	Observes whether urgency is explicitly, clearly communicated to the receiving specialist.
DOCUMENT *Urgent timeframe review*	Reviews whether a genuinely shorter identification timeframe applies to urgent referrals.

REFERENCES

[24] High variation in specialist wait times, correlated with lower documented appointment completion rates, is identified in referral system research, establishing that urgency-differentiated tracking, not uniform process application, is necessary to protect genuinely time-sensitive referrals.

Standard 5.4 · *Standard 5: Referral & Care Coordination*

Guidance & Learning

GUIDANCE ASF-PHC-STD5-v3.0

WHY THIS STANDARD EXISTS

Treating every referral identically, regardless of clinical urgency, means a genuinely time-sensitive concern gets no more protective attention than a routine one, and the real difference between a referral that can safely wait and one that genuinely cannot needs to translate into a real difference in how closely it's actually tracked.

The evidence: [24] High variation in specialist wait times, correlated with lower documented appointment completion rates, is identified in referral system research, establishing that urgency-differentiated tracking, not uniform process application, is necessary to protect genuinely time-sensitive referrals.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Urgent referrals genuinely receive more intensive tracking than routine ones.	✗ Every referral is tracked identically, regardless of clinical urgency.
✓ Urgency is explicitly, clearly communicated to the receiving specialist.	✗ Urgency is left for the specialist to infer, not explicitly communicated.
✓ A genuinely shorter timeframe governs identification of incomplete urgent referrals.	✗ The same timeframe applies to urgent and routine referrals alike.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Urgency is communicated verbally but not consistently documented in the referral itself.**
Documented urgency is more reliable than a verbal mention that may not reach everyone involved in processing the referral.

2 **A shorter timeframe exists for urgent referrals but isn't consistently applied in daily practice.**
A defined timeframe needs consistent application to provide genuine, reliable protection.

3 **Urgency differentiation is clear for obviously urgent cases but less consistent for moderately time-sensitive ones.**
Genuine clinical urgency exists on a real spectrum, not only at the most obvious extreme.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current referral tracking for genuine urgency differentiation.

Week 2 Establish explicit urgency communication and documentation for time-sensitive referrals.

Week 3 Define a genuinely shorter identification timeframe for urgent referrals.

Ongoing Audit urgent referral tracking specifically for consistent, meaningful differentiation.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, recent example of an urgent referral and how its tracking genuinely differed from a routine one.
A real, specific comparison reveals whether differentiation is genuine practice, not just policy language.

Ask how urgency is actually communicated to a receiving specialist for a specific referral.
A specific, confident answer reveals genuine, explicit communication, not an assumption it's understood.

E-LEARNING academy.gmj.ge/phc-std5-4-urgent-referral-tracking — 30 min · complete before self-assessment

Standard 5.5 **CORE** · *Standard 5: Referral & Care Coordination*

The Patient Is Actively Supported Through the Referral Process, Not Left to Navigate It Alone

ASSESSMENT ASF-PHC-STD5-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

5.5
CORE
L1

THE STANDARD

The Patient Is Actively Supported Through the Referral Process, Not Left to Navigate It Alone

The patient receives genuine, active support navigating the referral process — clear information about what to expect, help scheduling where needed, someone to contact with questions — not handed a referral and left entirely responsible for making it happen themselves.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the patient receive genuine, active support navigating the referral process, not just a referral handed over?** *Real, active support, not the patient left entirely responsible for making the referral happen.* Doc: Patient referral support documentation	YES	PARTIAL	NO
2	**Is there a specific person the patient can contact with questions or difficulties during the referral process?** *A real, known contact, not an assumption the patient will figure out who to ask.* Doc: Patient support contact information	YES	PARTIAL	NO
3	**Is there genuine follow-up with the patient if an initial specialist contact attempt doesn't result in scheduling?** *Real, active follow-up at exactly the most common failure point, not the process ending after one attempt.* Doc: Patient follow-up record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Patient support review*	Reviews evidence of genuine, active patient support through the referral process.
ASK *Patient contact interview*	Asks a patient whether they know who to contact with referral questions or difficulties.
DOCUMENT *Scheduling follow-up review*	Reviews whether genuine follow-up occurs when initial contact doesn't result in scheduling.

REFERENCES

[25] Research into referral process breakdowns identifies the gap between initial patient contact and actual appointment scheduling as the most common failure point, establishing active patient support through this specific stage as necessary to prevent referrals from being lost.

Standard 5.5 · *Standard 5: Referral & Care Coordination*

Guidance & Learning

GUIDANCE ASF-PHC-STD5-v3.0

WHY THIS STANDARD EXISTS

A significant share of referral failures occur specifically at the point where a patient is contacted but never actually scheduled, often because an initial contact attempt fails and no one follows up — a patient actively supported through this process, rather than left to navigate it entirely alone, is measurably less likely to fall through exactly this common gap.

The evidence: [25] Research into referral process breakdowns identifies the gap between initial patient contact and actual appointment scheduling as the most common failure point, establishing active patient support through this specific stage as necessary to prevent referrals from being lost.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Patients receive genuine, active support through the referral process.	✗ Patients are handed a referral and left entirely responsible for the rest.
✓ A specific, known contact exists for patient questions or difficulties.	✗ No specific contact exists for patient questions during the process.
✓ Genuine follow-up occurs when initial contact doesn't result in scheduling.	✗ The process ends after one contact attempt, regardless of whether scheduling occurred.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Support is offered proactively for complex referrals but less consistently for ones assumed to be straightforward.**
Any referral can genuinely stall at the contact-to-scheduling gap, not only complex ones.

2 **A contact exists but isn't clearly communicated to the patient at the time of referral.**
A contact the patient doesn't know about provides limited real support when they actually need it.

3 **Follow-up happens once after a failed contact attempt but isn't repeated if that follow-up also doesn't succeed.**
A single follow-up attempt that doesn't resolve the gap shouldn't end active support for the patient.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current patient support through the referral process, particularly at the contact-to-scheduling stage.

Week 2 Establish a clear, communicated contact for patient questions and difficulties.

Week 3 Build genuine follow-up practice for patients not successfully scheduled after initial contact.

Ongoing Track patient scheduling success specifically at this identified common failure point.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask a patient currently navigating a referral whether they know who to contact with questions.
A confident, specific answer reveals genuine, known support, not an assumed pathway.

Ask what happens when a specialist's office can't reach a patient on the first attempt.
A specific, real answer reveals whether follow-up genuinely happens at this common failure point.

E-LEARNING academy.gmj.ge/phc-std5-5-patient-referral-support — 30 min · complete before self-assessment

STANDARD 6

Clinical Environment & Safety

MANDATORY

5 criteria

Standard 6.1 **NON-NEGOTIABLE** · *Standard 6: Clinical Environment & Safety*

Test Results Are Tracked to Actual Action, Not Just Confirmed Receipt

ASSESSMENT ASF-PHC-STD6-v3.0

CR FULL	TR FULL	SM ADAPTED	ST FULL

6.1
NON-NEGOTIABLE
L1

THE STANDARD

Test Results Are Tracked to Actual Action, Not Just Confirmed Receipt

Every diagnostic test result is tracked not just to confirmed receipt by the clinician, but to actual, documented action taken in response — not assumed adequately handled simply because someone acknowledged seeing it.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Is every test result tracked to actual, documented action, not only confirmed receipt by the clinician?** *Genuine tracking of real action taken, not just acknowledgement of having seen the result.* Doc: Test result action tracking record	YES	PARTIAL	NO
2	**Is there a specific process for identifying a result that was received but never actually acted upon?** *A real, active identification process, not an assumption that receipt implies action.* Doc: Unactioned result identification process	YES	PARTIAL	NO
3	**Does the patient learn the actual result and its meaning, not just that a test was performed?** *Genuine, meaningful communication of the actual finding, not a passive assumption the patient will ask.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Action tracking review*	Reviews whether test results are tracked to genuine, documented action, not only receipt.
DOCUMENT *Unactioned result identification review*	Reviews the process for identifying results that were received but never acted upon.
ASK *Patient communication interview*	Asks a patient whether they received and understood the actual meaning of a specific test result.

REFERENCES

[26] Research on test result communication found that while automated notification systems statistically improved confirmed acknowledgement of test results, there was no corresponding improvement in documented actions taken in response, establishing that tracking to genuine action, not receipt alone, is necessary for real patient safety.

Standard 6.1 · *Standard 6: Clinical Environment & Safety*

Guidance & Learning

GUIDANCE ASF-PHC-STD6-v3.0

WHY THIS STANDARD EXISTS

Research specifically shows that confirming a clinician received and acknowledged a test result does not reliably mean any action was actually taken in response — receipt and action are genuinely different things, and a tracking system that only confirms the first provides false reassurance about the second.

The evidence: [26] Research on test result communication found that while automated notification systems statistically improved confirmed acknowledgement of test results, there was no corresponding improvement in documented actions taken in response, establishing that tracking to genuine action, not receipt alone, is necessary for real patient safety.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every result is tracked to genuine, documented action, not just receipt.	✗ Tracking confirms receipt but not whether any real action followed.
✓ A real process identifies results received but never acted upon.	✗ No process identifies results that were seen but never acted on.
✓ Patients genuinely learn and understand their actual results.	✗ Patients learn a test was done but not what it actually showed.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Action tracking is strong for abnormal results but less consistent for results confirming normal findings.**
Even a normal result needs genuine closure — the patient needs to know it was actually reviewed, not just filed.

2 **Results are acted on but the action taken isn't consistently documented in a way that's genuinely traceable later.**
An undocumented action is difficult to distinguish from no action at all during a later review.

3 **Patients are told results are available but not always given a genuine explanation of what they mean.**
Access to a result isn't the same as genuine understanding of its significance.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current test result tracking for genuine action tracking versus receipt confirmation alone.

Week 2 Establish a process for identifying results received but never actioned.

Week 3 Build a consistent practice for communicating actual result meaning to patients.

Ongoing Audit a sample of results to confirm genuine action, not just documented receipt.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to trace a specific abnormal result from receipt through to the actual action taken.
A real, traceable example reveals whether tracking captures genuine action, not just acknowledgement.

Ask a patient to explain what a recent test result actually showed.
This tests genuine communication and understanding, not just that results technically reached them.

E-LEARNING academy.gmj.ge/phc-std6-1-result-action-tracking — 30 min · complete before self-assessment

Standard 6.2 **NON-NEGOTIABLE** · *Standard 6: Clinical Environment & Safety*

History-Taking and Examination Follow a Structured Approach, Not Time-Pressured Shortcuts

ASSESSMENT ASF-PHC-STD6-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.2
NON-NEGOTIABLE
L1

THE STANDARD

History-Taking and Examination Follow a Structured Approach, Not Time-Pressured Shortcuts

History-taking and physical examination genuinely follow a structured, complete approach appropriate to the presenting concern — not abbreviated under time pressure in ways that consistently drive real diagnostic error.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Does history-taking genuinely follow a structured, complete approach, not abbreviated under time pressure?** *Real, structured completeness, not a shortcut taken to save time.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Does physical examination genuinely match what the presenting concern actually warrants, not a token, minimal check?** *Genuine, appropriate examination depth, not a cursory check regardless of the actual concern.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there a specific process supporting complete data gathering even during high-volume, time-pressured periods?** *A real, defined support process, not an assumption that thoroughness will hold up under pressure without help.* Doc: Structured data-gathering support documentation	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

OBSERVE *History-taking observation*	Observes an actual consultation for genuine, structured, complete history-taking.
OBSERVE *Examination adequacy observation*	Observes whether physical examination genuinely matches the presenting concern, not a minimal token check.
DOCUMENT *Time-pressure support review*	Reviews what specific support exists for maintaining thoroughness during high-volume periods.

REFERENCES

[27] A study of confirmed diagnostic errors in primary care found that patient-practitioner encounter breakdowns were primarily related to problems with history-taking, in 56.3 percent of cases, examination, in 47.4 percent of cases, and ordering diagnostic tests for further work-up, in 57.4 percent of cases.

Standard 6.2 · *Standard 6: Clinical Environment & Safety*

Guidance & Learning

GUIDANCE ASF-PHC-STD6-v3.0

WHY THIS STANDARD EXISTS

Research specifically found that the majority of confirmed diagnostic errors in primary care trace back to breakdowns in history-taking, examination, and test ordering during the actual clinical encounter — not to rare or exotic causes, but to genuinely common process breakdowns in exactly what should be the most basic, reliable part of any visit.

The evidence: [27] A study of confirmed diagnostic errors in primary care found that patient-practitioner encounter breakdowns were primarily related to problems with history-taking, in 56.3 percent of cases, examination, in 47.4 percent of cases, and ordering diagnostic tests for further work-up, in 57.4 percent of cases.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ History-taking is genuinely structured and complete, not abbreviated under pressure.	✗ History-taking is consistently abbreviated under time pressure.
✓ Examination genuinely matches what the presenting concern actually warrants.	✗ Examination is a token, minimal check regardless of the actual concern.
✓ A specific support process helps maintain thoroughness during high-volume periods.	✗ No support exists to help maintain thoroughness when volume is high.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Structured history-taking is strong for new patient visits but less consistent for brief follow-up encounters.**
Diagnostic error risk doesn't diminish just because a visit is framed as a quick follow-up.

2 **Examination depth is genuinely appropriate most of the time but noticeably reduced during the busiest periods.**
The real value of thorough examination doesn't diminish when the clinic happens to be busy.

3 **A structured template exists but isn't consistently used across all clinicians in the practice.**
A structured approach needs consistent use to provide genuine, reliable protection against process breakdown.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current history-taking and examination practice for consistency, particularly under time pressure.

Week 2 Establish or reinforce a structured approach appropriate to common presenting concerns.

Week 3 Build specific support for maintaining thoroughness during high-volume periods.

Ongoing Audit consultation quality periodically, including during genuinely busy periods.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe a consultation during a genuinely busy period specifically.
This is where structured thoroughness is most likely to erode under real pressure.

Ask a clinician how they maintain thoroughness when the schedule is significantly overbooked.
A specific, thoughtful answer reveals genuine practice, not an assumption it holds up automatically.

E-LEARNING academy.gmj.ge/phc-std6-2-structured-history-examination — 30 min · complete before self-assessment

Standard 6.3 **NON-NEGOTIABLE** · *Standard 6: Clinical Environment & Safety*

Medication Safety Follows Defined Processes for Prescribing and Monitoring

ASSESSMENT ASF-PHC-STD6-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

6.3
NON-NEGOTIABLE
L1

THE STANDARD

Medication Safety Follows Defined Processes for Prescribing and Monitoring

Prescribing, dispensing, and ongoing monitoring of medications follow specific, defined safety processes — genuine allergy and interaction checking, clear instructions, monitoring where clinically required — not left to individual clinician memory and informal practice alone.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does prescribing follow a defined process for genuine allergy and interaction checking, not reliance on memory alone?** *A real, systematic check, not individual clinician memory as the only safeguard.* Doc: Prescribing safety check documentation	YES	PARTIAL	NO
2	**Do patients receive clear, understandable instructions for new or changed medications, verified as understood?** *Genuine, verified understanding, not instructions given without confirmation.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is monitoring genuinely scheduled and tracked for medications that clinically require it, not left to chance?** *Real, scheduled, tracked monitoring, not an assumption it will happen without a defined process.* Doc: Medication monitoring schedule	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Prescribing safety review*	Reviews the defined process for allergy and interaction checking at prescribing.
OBSERVE *Patient instruction observation*	Observes whether patients receive clear instructions with verified understanding.
DOCUMENT *Monitoring schedule review*	Reviews whether required medication monitoring is genuinely scheduled and tracked.

REFERENCES

[28] Preventable adverse drug events are estimated to affect approximately 2 percent of adult outpatients, with primary care clinicians, when systematically surveyed, identifying specific, addressable process gaps in prescribing, quality assurance, and patient education as the primary drivers of preventable medication error.

Standard 6.3 · *Standard 6: Clinical Environment & Safety*

Guidance & Learning

GUIDANCE ASF-PHC-STD6-v3.0

WHY THIS STANDARD EXISTS

Medication errors are among the most common and costly patient safety incidents in primary care specifically, and clinicians themselves, when asked directly, consistently identify concrete, addressable process gaps — meaning this isn't an unsolvable problem, but one that requires genuinely defined processes rather than individual vigilance alone.

The evidence: [28] Preventable adverse drug events are estimated to affect approximately 2 percent of adult outpatients, with primary care clinicians, when systematically surveyed, identifying specific, addressable process gaps in prescribing, quality assurance, and patient education as the primary drivers of preventable medication error.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A defined, systematic process genuinely checks allergies and interactions at prescribing.	✗ Allergy and interaction checking relies on individual clinician memory alone.
✓ Patients receive clear instructions with verified understanding.	✗ Instructions are given without verifying genuine patient understanding.
✓ Required monitoring is genuinely scheduled and tracked, not left to chance.	✗ Monitoring for medications that require it isn't reliably scheduled or tracked.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Interaction checking is systematic for new prescriptions but not rechecked when an additional medication is later added.**
Interaction risk applies at the point combinations actually occur, not only at each medication's original prescribing.

2 **Instructions are given clearly but understanding isn't actively verified, particularly for complex regimens.**
Complex regimens carry genuinely higher risk of misunderstanding and benefit from active verification.

3 **Monitoring is scheduled but follow-through when a patient misses a monitoring appointment is inconsistent.**
A monitoring schedule needs a defined response when it isn't met, not silent gaps.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current prescribing practice for systematic allergy and interaction checking.

Week 2 Establish patient instruction verification, particularly for complex medication regimens.

Week 3 Build a defined monitoring schedule with follow-up for missed monitoring.

Ongoing Audit prescribing safety checks and monitoring completion periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask how the practice checks for interactions when a second medication is added to an existing regimen.
This reveals whether checking is genuinely systematic, not limited to initial prescribing alone.

Ask a patient to explain back the instructions for a recently prescribed medication.
A specific, confident answer reveals genuine understanding, not assumed comprehension.

E-LEARNING academy.gmj.ge/phc-std6-3-medication-safety — 30 min · complete before self-assessment

Standard 6.4 **NON-NEGOTIABLE** · *Standard 6: Clinical Environment & Safety*

Point-of-Care Testing Is Genuinely Reliable, Verified Against a Recognised Standard

ASSESSMENT ASF-PHC-STD6-v3.0

CR FULL	TR FULL	SM ADAPTED	ST FULL

6.4
NON-NEGOTIABLE
L1

THE STANDARD

Point-of-Care Testing Is Genuinely Reliable, Verified Against a Recognised Standard

Point-of-care diagnostic testing performed at the clinic is verified as genuinely accurate against a recognised quality standard — regular calibration, quality control checks — not simply assumed reliable because the device is in use and produces a result.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Is point-of-care testing genuinely verified as accurate against a recognised quality standard, not assumed reliable?** *Real, verified accuracy, not an assumption based on the device simply producing a result.* Doc: Quality control verification record	YES	PARTIAL	NO
2	**Are regular calibration and quality control checks genuinely performed and documented?** *Real, scheduled, documented checks, not skipped or assumed unnecessary.* Doc: Calibration and QC schedule documentation	YES	PARTIAL	NO
3	**Is there a specific process for what happens if a quality control check fails?** *A real, defined response, not testing continuing regardless of a failed check.* Doc: QC failure response protocol	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Verification record review*	Reviews evidence that point-of-care testing is genuinely verified against a recognised standard.
DOCUMENT *Calibration schedule review*	Reviews records of regular, documented calibration and quality control checks.
ASK *QC failure response interview*	Asks staff what specifically happens if a quality control check fails.

REFERENCES

[29] The World Health Organization has specifically called for point-of-care diagnostic methods designed to function reliably in settings with limited access to laboratory services, establishing genuine, verified accuracy — not mere availability of a testing device — as essential to the real clinical value of point-of-care testing.

Standard 6.4 · *Standard 6: Clinical Environment & Safety*

Guidance & Learning

GUIDANCE ASF-PHC-STD6-v3.0

WHY THIS STANDARD EXISTS

Point-of-care testing carries genuine, specific value in exactly the resource-limited and remote settings where laboratory access is difficult, but a device that produces a result without genuine, verified accuracy provides false confidence that can be worse than no test at all — the real value depends entirely on the result being genuinely trustworthy.

The evidence: [29] The World Health Organization has specifically called for point-of-care diagnostic methods designed to function reliably in settings with limited access to laboratory services, establishing genuine, verified accuracy — not mere availability of a testing device — as essential to the real clinical value of point-of-care testing.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Point-of-care testing is genuinely verified as accurate against a recognised standard.	✗ Testing is assumed reliable simply because the device produces a result.
✓ Calibration and quality control checks are regularly performed and documented.	✗ Calibration and quality control checks are skipped or undocumented.
✓ A specific, defined response exists for a failed quality control check.	✗ No specific process exists for a failed quality control check.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Quality control checks happen but documentation is inconsistent, making genuine verification difficult to confirm.**
Undocumented checks are difficult to distinguish from checks that didn't genuinely happen.

2 **Checks are performed on a schedule but staff aren't fully confident in interpreting a genuinely failed result.**
A quality control system's real value depends on staff correctly recognising and responding to failure.

3 **Verification happens for the most frequently used tests but not consistently across all point-of-care devices.**
Every point-of-care device in use deserves the same genuine verification discipline.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current point-of-care testing for genuine verification versus assumed reliability.

Week 2 Establish a regular, documented calibration and quality control schedule.

Week 3 Train staff on recognising and responding to a failed quality control check.

Ongoing Audit calibration and quality control documentation periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual calibration and quality control log for a specific point-of-care device.
A real, specific record is the evidence of genuine verification, not assumed reliability.

Ask staff what they would do if a quality control check came back outside acceptable range.
A specific, confident answer reveals genuine understanding, not assumed competence.

E-LEARNING academy.gmj.ge/phc-std6-4-point-of-care-testing — 30 min · complete before self-assessment

Standard 6.5 **CORE** · *Standard 6: Clinical Environment & Safety*

The Clinical Environment Itself Supports Safe Care, Not Just Administrative Compliance

ASSESSMENT ASF-PHC-STD6-v3.0

CR ADAPTED	TR FULL	SM ADAPTED	ST FULL

6.5
CORE
L1

THE STANDARD

The Clinical Environment Itself Supports Safe Care, Not Just Administrative Compliance

The physical clinical environment — equipment maintenance, infection control supplies, adequate space for examination and privacy — genuinely supports safe patient care, not simply meets a documentation checklist while real, everyday practice tells a different story.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does equipment maintenance genuinely reflect real, current condition, not just a completed checklist?** *Real, verified equipment condition, not documentation completed without genuine follow-through.* Doc: Equipment maintenance record	YES	PARTIAL	NO
2	**Are infection control supplies genuinely, consistently available at the point of use, not just stocked somewhere in the building?** *Real, practical availability where actually needed, not theoretical stock elsewhere.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does examination space genuinely support patient privacy and dignity, not just meet a minimal documented standard?** *Real, practical privacy in daily use, not a standard met only on paper.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Equipment condition observation*	Physically checks equipment for genuine, current functional condition, not just documented maintenance.
OBSERVE *Supply availability observation*	Checks infection control supplies for genuine availability at the actual point of use.
OBSERVE *Privacy observation*	Assesses whether examination space genuinely supports patient privacy and dignity in real practice.

REFERENCES

[30] World Health Organization data indicate that as many as 4 in 10 patients are harmed in primary and ambulatory care settings, with up to 80 percent of this harm considered avoidable, establishing the genuine, everyday clinical environment, not documentation alone, as a real determinant of patient safety.

Standard 6.5 · *Standard 6: Clinical Environment & Safety*

Guidance & Learning

GUIDANCE ASF-PHC-STD6-v3.0

WHY THIS STANDARD EXISTS

Real patient harm in primary and ambulatory settings is genuinely common and substantially avoidable, and the physical environment a clinic actually operates in — not just what's documented as compliant — is part of what determines whether that avoidable harm actually happens here.

The evidence: [30] World Health Organization data indicate that as many as 4 in 10 patients are harmed in primary and ambulatory care settings, with up to 80 percent of this harm considered avoidable, establishing the genuine, everyday clinical environment, not documentation alone, as a real determinant of patient safety.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Equipment condition genuinely reflects real, current function, not just documentation.	✗ Equipment maintenance is documented but real condition doesn't match.
✓ Infection control supplies are genuinely available where actually needed.	✗ Supplies are stocked somewhere but not genuinely available at the point of use.
✓ Examination space genuinely supports privacy and dignity in daily practice.	✗ Examination space technically exists but doesn't genuinely support privacy in practice.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Equipment is generally well-maintained but a specific item has been overdue for service without genuine follow-through.**
Every piece of equipment deserves the same genuine maintenance discipline, not just most of them.

2 **Supplies are usually available but occasionally run short during high-volume periods.**
Genuine availability needs to hold up specifically when demand is highest, not only under typical conditions.

3 **Privacy is generally respected but the physical space creates specific, recurring compromises during busy periods.**
Genuine privacy shouldn't depend on how busy the clinic happens to be at a given moment.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Physically assess the clinical environment for genuine, real-world safety support, not documentation alone.

Week 2 Address any gap between documented equipment maintenance and actual current condition.

Week 3 Confirm infection control supplies are genuinely available at every actual point of use.

Ongoing Periodically reassess the physical environment against genuine, practical safety and privacy standards.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Physically check equipment condition directly, not just review maintenance documentation.
Direct observation reveals genuine condition, not assumed adequacy from paperwork.

Observe the examination space during a busy period specifically.
This is where genuine privacy and safety support are most likely to be tested.

E-LEARNING academy.gmj.ge/phc-std6-5-clinical-environment — 30 min · complete before self-assessment

STANDARD 7

Governance & Staffing

MANDATORY

5 criteria

Standard 7.1 **NON-NEGOTIABLE** · *Standard 7: Governance & Staffing*

A Defined Coverage Plan Exists for When the Solo Doctor Is Unavailable

ASSESSMENT ASF-PHC-STD7-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.1
NON-NEGOTIABLE
L1

THE STANDARD

A Defined Coverage Plan Exists for When the Solo Doctor Is Unavailable

A genuine, defined coverage arrangement exists for when the practice's own doctor is unavailable — illness, leave, emergency — with a real, named alternative for patients needing care in that gap, not an assumption that patients will simply wait or seek care elsewhere on their own.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does a genuine, defined coverage arrangement exist for when the doctor is unavailable?** *A real, specific arrangement, not an assumption that patients will manage without care.* Doc: Coverage arrangement documentation	YES	PARTIAL	NO
2	**Is there a real, named alternative provider or facility patients can be directed to during a coverage gap?** *A specific, real alternative, not a vague suggestion to seek care elsewhere.* Doc: Named alternative provider documentation	YES	PARTIAL	NO
3	**Are patients genuinely informed of the coverage plan, not left to discover it only when they need it?** *Real, proactive patient awareness, not information they only encounter during an actual gap.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Coverage plan review*	Reviews the actual, defined coverage arrangement for when the doctor is unavailable.
DOCUMENT *Alternative provider review*	Reviews the specific, named alternative provider or facility patients would be directed to.
ASK *Patient awareness interview*	Asks a patient whether they know what to do if the practice's doctor were unavailable.

REFERENCES

[31] Continuity of care functions as genuine infrastructure protecting both patient outcomes and the rural primary care workforce itself, establishing defined coverage arrangements, distinct from unplanned care gaps, as essential to sustaining this infrastructure specifically in solo and small rural practice.

Standard 7.1 · *Standard 7: Governance & Staffing*

Guidance & Learning

GUIDANCE ASF-PHC-STD7-v3.0

WHY THIS STANDARD EXISTS

Continuity of care, the entire foundation this document is built around, has a real, specific vulnerability in a genuine solo practice that a larger team doesn't face in the same way — when the one doctor is unavailable, without a defined coverage plan, every patient's continuity simply stops, at exactly the moment it might matter most.

The evidence: [31] Continuity of care functions as genuine infrastructure protecting both patient outcomes and the rural primary care workforce itself, establishing defined coverage arrangements, distinct from unplanned care gaps, as essential to sustaining this infrastructure specifically in solo and small rural practice.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuine, defined coverage arrangement exists and is real, not theoretical.	✗ No defined coverage arrangement exists beyond an assumption patients will manage.
✓ A specific, named alternative provider is identified for coverage gaps.	✗ No specific alternative is identified; patients are vaguely told to seek care elsewhere.
✓ Patients are genuinely, proactively aware of the coverage plan.	✗ Patients only learn about coverage gaps when they actually encounter one.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A coverage plan exists for planned absences but not genuinely for sudden, unplanned unavailability.**
A genuine emergency doesn't announce itself in advance, and the plan needs to cover this reality too.

2 **An alternative provider is named but the relationship hasn't been recently reconfirmed as still active.**
A coverage relationship needs to remain genuinely active, not just historically established.

3 **The plan exists but patient awareness relies on them happening to ask, not proactive communication.**
Genuine, proactive awareness is more reliable than a plan patients only discover by chance.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current coverage arrangements for genuine readiness, including sudden, unplanned absence.

Week 2 Establish or reconfirm a specific, named alternative provider relationship.

Week 3 Build proactive patient communication about the coverage plan.

Ongoing Periodically reconfirm the coverage relationship remains genuinely active.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask what specifically would happen if the doctor became suddenly, unexpectedly unavailable today.
A specific, confident answer reveals a genuine plan, not an assumption it would work out.

Ask a patient directly whether they know what to do if the doctor were unavailable.
This tests genuine, proactive awareness, not an assumption patients would figure it out.

E-LEARNING academy.gmj.ge/phc-std7-1-coverage-plan — 30 min · complete before self-assessment

	Standard 7.2 NON-NEGOTIABLE · *Standard 7: Governance & Staffing* **Physician Wellbeing Is Actively Monitored and Supported, Not Left to Individual Resilience Alone**	ASSESSMENT ASF-PHC-STD7-v3.0
CR ADAPTED	TR FULL	SM FULL / ST FULL

7.2
NON-NEGOTIABLE
L1

THE STANDARD

Physician Wellbeing Is Actively Monitored and Supported, Not Left to Individual Resilience Alone

The physician's own wellbeing and burnout risk is genuinely, actively monitored and supported — real access to support, genuine attention to sustainable workload — not treated as a private matter left entirely to individual resilience with no structural attention at all.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is physician wellbeing genuinely, actively monitored, not treated as a purely private matter?** *Real, active attention, not an assumption that wellbeing is solely the individual's own concern.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Does the physician have genuine, real access to support if burnout risk is identified?** *Actual, accessible support, not a theoretical resource that's difficult to genuinely use.* Doc: Support access documentation	YES	PARTIAL	NO
3	**Is workload genuinely, periodically reviewed for sustainability, not assumed manageable indefinitely?** *Real, periodic review, not an assumption the current pace is sustainable without ever checking.* Doc: Workload review record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
ASK *Wellbeing monitoring interview*	Asks the physician directly whether their own wellbeing receives genuine, active attention.
DOCUMENT *Support access review*	Reviews what genuine, accessible support exists if burnout risk is identified.
DOCUMENT *Workload review documentation*	Reviews evidence of periodic, genuine workload sustainability review.

REFERENCES

[32] Agency for Healthcare Research and Quality research found that more than one quarter of physicians in small- and medium-sized primary care practices experience moderate to severe burnout, with rural clinicians reporting the highest rates, and established that burnout measurably impairs attention, memory, and executive function with direct implications for patient safety.

Standard 7.2 · *Standard 7: Governance & Staffing*

Guidance & Learning

GUIDANCE ASF-PHC-STD7-v3.0

WHY THIS STANDARD EXISTS

Research specifically shows rural and small-practice clinicians experience the highest rates of burnout among primary care providers, and burnout isn't only a wellbeing concern — it measurably impairs attention, memory, and executive function, meaning a burned-out physician represents genuine, real patient safety risk, not simply a private struggle with no bearing on care quality.

The evidence: [32] Agency for Healthcare Research and Quality research found that more than one quarter of physicians in small- and medium-sized primary care practices experience moderate to severe burnout, with rural clinicians reporting the highest rates, and established that burnout measurably impairs attention, memory, and executive function with direct implications for patient safety.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Physician wellbeing receives genuine, active attention, not treated as purely private.	✗ Wellbeing is treated as an entirely private matter with no structural attention.
✓ Real, accessible support exists if burnout risk is identified.	✗ No genuine, accessible support exists beyond a theoretical resource.
✓ Workload is genuinely, periodically reviewed for sustainability.	✗ Workload sustainability is assumed, never genuinely reviewed.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Attention to wellbeing happens informally but isn't structured into any genuine, regular process.**
Informal attention is less reliable than a genuine, structured practice that doesn't depend on someone happening to notice.

2 **Support resources exist but are genuinely difficult to access given the demands of solo practice.**
A resource that's difficult to actually use in practice provides limited real protective value.

3 **Workload review happens but doesn't lead to genuine adjustment even when sustainability concerns are identified.**
A review without real, resulting action doesn't provide the genuine protection this criterion exists to ensure.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current attention to physician wellbeing for genuine structure versus informal assumption.

Week 2 Establish genuine, accessible support specifically feasible for solo practice demands.

Week 3 Build a periodic, structured workload sustainability review.

Ongoing Act on genuine sustainability concerns identified through review.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask the physician directly about their own current workload sustainability and access to support.
A genuine, honest answer reveals real practice, not an assumption everything is fine.

Ask what specifically changed the last time a wellbeing or workload concern was identified.
A real, specific example reveals whether attention leads to genuine action, not just awareness.

E-LEARNING academy.gmj.ge/phc-std7-2-physician-wellbeing — 30 min · complete before self-assessment

Standard 7.3 **CORE** · *Standard 7: Governance & Staffing*

A Genuine Quality Improvement Process Exists, Even at Small Scale

ASSESSMENT ASF-PHC-STD7-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

7.3
CORE
L1

THE STANDARD

A Genuine Quality Improvement Process Exists, Even at Small Scale

The practice maintains a genuine, ongoing quality improvement process — even a small, single, well-chosen project — not the absence of any structured improvement effort simply because the practice is too small for a formal committee structure.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Does the practice maintain a genuine, ongoing quality improvement effort, even at small scale?** *A real, specific improvement effort, not the absence of one justified by practice size.* Doc: Quality improvement project documentation	YES	PARTIAL	NO
2	**Is the improvement effort based on a real, identified gap specific to this practice, not a generic exercise?** *Genuine, specific relevance to this practice's actual circumstances, not a generic template.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is there real evidence the improvement effort has produced a genuine, measurable change?** *Actual, measurable outcome, not activity without demonstrated real effect.* Doc: Improvement outcome evidence	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Improvement project review*	Reviews the practice's genuine, ongoing quality improvement effort, however small in scale.
ASK *Relevance interview*	Asks the physician how the improvement effort relates to a real, identified gap in this specific practice.
DOCUMENT *Outcome evidence review*	Reviews evidence of genuine, measurable change resulting from the improvement effort.

REFERENCES

[33] Quality improvement initiatives adapted for solo and small primary care practices, including structured support models and micro-scale improvement projects, are established as genuinely effective and appropriate to practice size, distinct from an assumption that meaningful quality improvement requires large-scale infrastructure.

Standard 7.3 · *Standard 7: Governance & Staffing*

Guidance & Learning

GUIDANCE ASF-PHC-STD7-v3.0

WHY THIS STANDARD EXISTS

Quality improvement doesn't require a large committee to be genuine — even a solo practitioner can identify a specific, real quality gap and work through a structured improvement cycle, and the absence of this genuine practice, not the absence of formal infrastructure, is what actually represents a real gap in this standard.

The evidence: [33] Quality improvement initiatives adapted for solo and small primary care practices, including structured support models and micro-scale improvement projects, are established as genuinely effective and appropriate to practice size, distinct from an assumption that meaningful quality improvement requires large-scale infrastructure.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A genuine, ongoing improvement effort exists, appropriately scaled to the practice. ✓ The effort addresses a real, specific gap identified in this practice. ✓ Real evidence shows a genuine, measurable resulting change.	✗ No genuine improvement effort exists, treated as unnecessary given small practice size. ✗ Any improvement activity is generic, not genuinely relevant to this practice's real circumstances. ✗ No evidence connects improvement activity to any genuine, measurable change.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **An improvement effort was started but hasn't been genuinely completed or evaluated.**
A genuine improvement cycle needs to reach evaluation to demonstrate real, meaningful effect.

2 **The chosen focus is reasonable but wasn't specifically selected based on this practice's own real data or experience.**
Genuine relevance comes from grounding the effort in this practice's actual circumstances, not a generic priority.

3 **A change was made but wasn't genuinely measured to confirm it produced real improvement.**
An unmeasured change is difficult to distinguish from a change that didn't actually help.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Identify a real, specific quality gap genuinely relevant to this practice.

Week 2 Design a small, appropriately scaled improvement effort addressing this gap.

Week 3 Implement the improvement and establish a way to genuinely measure its effect.

Ongoing Evaluate the improvement effort and identify the next genuine priority.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask what specific quality gap the current improvement effort is genuinely addressing.
A specific, real answer reveals genuine relevance, not a generic exercise.

Ask for real evidence the improvement effort actually changed something measurable.
A specific, real outcome reveals genuine effect, not activity alone.

E-LEARNING academy.gmj.ge/phc-std7-3-small-scale-quality-improvement — 30 min · complete before self-assessment

	Standard 7.4 NON-NEGOTIABLE · *Standard 7: Governance & Staffing* **Staff, However Few, Receive Real, Documented Training for Their Actual Role**	ASSESSMENT ASF-PHC-STD7-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

7.4
NON-NEGOTIABLE
L1

THE STANDARD

Staff, However Few, Receive Real, Documented Training for Their Actual Role

Every staff member, however few the practice employs, receives genuine, documented training specific to their actual role — not informal, on-the-job learning alone with no structured content or verification of competency.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does every staff member receive genuine, documented training specific to their actual role?** *Real, structured training with documentation, not informal on-the-job learning alone.* Doc: Staff training record	YES	PARTIAL	NO
2	**Is competency genuinely verified, not simply assumed from time spent in the role?** *Real, active verification, not an assumption that tenure alone confirms competency.* Doc: Competency verification record	YES	PARTIAL	NO
3	**Is training genuinely refreshed periodically, not completed once and never revisited?** *Real, ongoing training, not a single initial session treated as sufficient indefinitely.* Doc: Ongoing training schedule	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Training record review*	Reviews documented, structured training for every staff member, however few.
DOCUMENT *Competency verification review*	Reviews evidence that competency is genuinely verified, not assumed from tenure.
DOCUMENT *Ongoing training review*	Reviews whether training is genuinely refreshed periodically.

REFERENCES

[34] Structured training and competency verification, distinct from informal on-the-job learning alone, is established practice for genuine patient safety regardless of practice size, with quality improvement support models specifically developed to extend structured training support to small and solo practices.

Standard 7.4 · *Standard 7: Governance & Staffing*

Guidance & Learning

GUIDANCE ASF-PHC-STD7-v3.0

WHY THIS STANDARD EXISTS

A practice with very few staff can genuinely underinvest in structured training precisely because informal, on-the-job learning feels sufficient for a small team — but the real risk a specific task carries doesn't diminish just because the practice is small, and every staff member's actual competency deserves the same genuine verification regardless of team size.

The evidence: [34] Structured training and competency verification, distinct from informal on-the-job learning alone, is established practice for genuine patient safety regardless of practice size, with quality improvement support models specifically developed to extend structured training support to small and solo practices.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every staff member receives genuine, documented, structured training.	✗ Training relies entirely on informal, on-the-job learning with no structure.
✓ Competency is genuinely verified, not assumed from time in role.	✗ Competency is assumed from tenure, never actively verified.
✓ Training is genuinely refreshed periodically, not a one-time event.	✗ Training happens once and is never revisited.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Training is documented for clinical tasks but less structured for administrative or support roles.**
Every role, including administrative ones, carries real responsibilities that benefit from genuine, structured training.

2 **Initial training is thorough but ongoing refresher training is inconsistent.**
Skills and knowledge benefit from genuine, periodic reinforcement, not a single strong initial session alone.

3 **Training happens but competency verification relies on informal observation rather than a genuine, structured check.**
A structured verification process is more reliable than informal impression alone.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current staff training for genuine structure versus informal on-the-job learning.

Week 2 Build structured, documented training for every staff role, including administrative.

Week 3 Establish genuine competency verification, not assumed from tenure.

Ongoing Refresh training periodically for all staff.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see the actual, documented training record for a specific staff member.
A specific, real record reveals genuine structure, not informal learning assumed sufficient.

Ask an administrative or support staff member about their own specific training.
This reveals whether structured training genuinely extends beyond clinical roles.

E-LEARNING academy.gmj.ge/phc-std7-4-staff-training — 30 min · complete before self-assessment

	Standard 7.5 NON-NEGOTIABLE · *Standard 7: Governance & Staffing* **Incident Reporting Leads to Genuine Learning, Not Just Documentation**	ASSESSMENT ASF-PHC-STD7-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

7.5
NON-NEGOTIABLE
L1

THE STANDARD

Incident Reporting Leads to Genuine Learning, Not Just Documentation

When something goes wrong or nearly goes wrong, the practice genuinely reviews what happened and why, with real, documented change resulting where warranted — not an incident logged and filed without any real reflection or resulting action.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**When something goes wrong or nearly does, is there genuine review of what happened and why?** *Real, active reflection, not an incident simply logged and filed.* Doc: Incident review record	YES	PARTIAL	NO
2	**Does this review result in genuine, documented change where warranted, not review without action?** *Real, resulting change, not reflection that doesn't translate into any actual adjustment.* Doc: Resulting change documentation	YES	PARTIAL	NO
3	**Are near-misses genuinely reviewed with the same seriousness as actual incidents, not dismissed because no harm occurred?** *Genuine attention to near-misses, not only events that actually resulted in harm.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Incident review record review*	Reviews evidence of genuine reflection on what happened and why for real incidents.
DOCUMENT *Resulting change review*	Reviews whether genuine, documented change resulted from incident review where warranted.
ASK *Near-miss attention interview*	Asks the physician how near-misses are genuinely reviewed, not just actual incidents.

REFERENCES

[35] Genuine review and resulting practice change following an incident, distinct from documentation alone, is established as essential to meaningful quality improvement and patient safety learning in primary care, regardless of practice size or formal committee structure.

Standard 7.5 · *Standard 7: Governance & Staffing*

Guidance & Learning

GUIDANCE ASF-PHC-STD7-v3.0

WHY THIS STANDARD EXISTS

An incident report that exists only as documentation, without genuine reflection on why it happened and what should change, provides none of the real protective value incident reporting is meant to offer — the whole point is learning from what actually happened, not simply creating a record that it did.

The evidence: [35] Genuine review and resulting practice change following an incident, distinct from documentation alone, is established as essential to meaningful quality improvement and patient safety learning in primary care, regardless of practice size or formal committee structure.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Real incidents receive genuine review of what happened and why.	✗ Incidents are logged without genuine reflection on cause.
✓ Review genuinely results in documented change where warranted.	✗ Review happens but doesn't translate into any real, resulting change.
✓ Near-misses receive the same genuine attention as actual incidents.	✗ Near-misses are dismissed because no actual harm occurred.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Review happens for significant incidents but not consistently for smaller, less dramatic ones.**
Smaller incidents can still reveal genuine, real patterns worth understanding.

2 **Review is thorough but resulting changes aren't consistently tracked to confirm they were actually implemented.**
An identified change that isn't tracked to genuine implementation may not actually happen.

3 **Near-misses are occasionally reviewed but not as a genuine, consistent practice.**
Consistent review of near-misses provides earlier, more reliable learning than occasional attention alone.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current incident handling for genuine reflection versus documentation alone.

Week 2 Establish a genuine review process covering both actual incidents and near-misses.

Week 3 Build tracking to confirm identified changes are genuinely implemented.

Ongoing Review incident and near-miss patterns periodically for genuine learning.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, specific example of an incident review and what actually changed as a result.
A real, traceable example reveals genuine learning, not documentation alone.

Ask about a recent near-miss and how it was genuinely reviewed.
This reveals whether near-misses receive real attention, not only events that caused actual harm.

E-LEARNING academy.gmj.ge/phc-std7-5-incident-learning — 30 min · complete before self-assessment

Endorsements

What follows is an optional endorsement — an additional standard layered on top of the base seven, never issued alone. A clinic must genuinely pass Standards 1 through 7 before the endorsement below is assessed. "Primary Health Clinic" alone means the base seven only. "Primary Health Clinic + Health & Migration" means the base seven, verified first, plus the endorsement that follows.

STANDARD 8

Health & Migration

OPTIONAL ENDORSEMENT

Requires Standards 1–7 verified first

10 criteria

	Standard 8.1 **NON-NEGOTIABLE** · *Standard 8: Health & Migration* **People-Centred Care Adapted to Migration and Displacement Experience**	**ASSESSMENT** ASF-PHC-STD8-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

8.1
NON-NEGOTIABLE
L1

THE STANDARD

People-Centred Care Adapted to Migration and Displacement Experience

Care is genuinely adapted to a patient's migration and displacement experience — including trauma-informed practice, awareness of legal-status barriers to access, and support for continuity of care — not delivered identically regardless of that history.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is care genuinely adapted to a patient's migration and displacement experience, not delivered identically regardless of history?** *Genuine adaptation, not a generic cultural-awareness statement.* Doc: Training record on migration-adapted care	YES	PARTIAL	NO
2	**Is trauma-informed practice genuinely applied, not just referenced as a principle?** *Actual practice adaptation, not an assumption of general sensitivity.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are staff aware of legal-status barriers to access that may affect this specific patient?** *Specific awareness, not a general sense that barriers can exist.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
ASK *Migration-adapted care interview*	Asks staff how they adapt practice specifically for a patient's migration and displacement history.
OBSERVE *Trauma-informed practice observation*	Observes an actual consultation for genuine trauma-informed practice, not generic sensitivity.
DOCUMENT *Training content review*	Reviews training materials for specific coverage of migration-adapted, trauma-informed care.

REFERENCES

[36] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

Standard 8.1 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-PHC-STD8-v3.0

WHY THIS STANDARD EXISTS

A refugee or migrant patient's health needs and vulnerabilities are shaped by what happened before they ever reached this clinic — in their country of origin, in transit, and on arrival — and for a clinic that may be this patient's very first contact with a new health system, care that ignores this context misses real, clinically relevant information from the outset.

The evidence: [36] WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Care is genuinely, visibly adapted to migration and displacement history.	✗ Care is delivered identically regardless of migration history.
✓ Trauma-informed practice is actually applied, not just referenced.	✗ Trauma-informed practice exists only as a stated principle, not applied practice.
✓ Staff demonstrate specific awareness of legal-status access barriers.	✗ Staff show no specific awareness of legal-status barriers.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Adaptation happens for patients who disclose their history but isn't proactively considered otherwise.**
Not every patient will volunteer this history unprompted, even when it is clinically relevant.

2 **Staff are aware of the principle but haven't received specific training on applying it.**
General awareness doesn't reliably translate into genuine practice adaptation without specific training.

3 **Adaptation is strong for the first visit but isn't sustained as the patient continues in ongoing primary care.**
An ongoing relationship depends on this understanding genuinely persisting, not fading after the initial encounter.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine adaptation to migration and displacement history.

Week 2 Train staff specifically on trauma-informed, migration-adapted practice.

Week 3 Build awareness of legal-status access barriers into standard practice.

Ongoing Revisit adaptation as the ongoing patient relationship develops.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to describe a specific example of adapting care for a patient's migration history.
A real, specific example reveals genuine practice, not familiarity with the principle.

Ask about continuity of care support specifically for patients without stable documentation.
This is where genuine adaptation is most tested.

E-LEARNING academy.gmj.ge/phc-std8-1-migration-adapted-care — 30 min · complete before self-assessment

	Standard 8.2 NON-NEGOTIABLE · *Standard 8: Health & Migration* **Supporting Patient Agency Through Genuine Understanding of Care and the Health System**	ASSESSMENT ASF-PHC-STD8-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

8.2
NON-NEGOTIABLE
L1

THE STANDARD

Supporting Patient Agency Through Genuine Understanding of Care and the Health System

Patients are supported to genuinely understand both their own care and how to navigate the wider health system — with understanding actively verified through methods like teach-back, in plain language, not assumed from silence, a nod, or general goodwill information about the system.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is understanding actively checked using teach-back, for both the care plan and how the system works?** *Asking the patient to explain back in their own words, not just "do you understand?"* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Is practical guidance given on navigating the wider system, including registering elsewhere if they relocate?** *Real navigation guidance beyond this one clinic, not general encouragement.* Doc: Navigation guidance material	YES	PARTIAL	NO
3	**Is information communicated in plain language, particularly when working through an interpreter?** *Complex terminology strains interpretation and comprehension together.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Teach-back practice observation*	Observes a consultation, or a simulated scenario, to check whether teach-back genuinely verifies understanding of both care and system navigation.
DOCUMENT *Navigation material review*	Reviews any materials or guidance provided on navigating the wider health system, in relevant languages.
ASK *Patient understanding check*	Asks a recent refugee or migrant patient to explain back their care plan and how they would access care again, including elsewhere if needed.

REFERENCES

[37] WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

Standard 8.2 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-PHC-STD8-v3.0

WHY THIS STANDARD EXISTS

For a refugee or migrant patient whose primary health clinic may be their first genuine contact with an entirely new health system, understanding how that system actually works matters as much as understanding any single care decision — a patient who nods along without genuinely understanding can carry that incomplete picture into every future encounter across the entire system.

The evidence: [37] WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Teach-back genuinely verifies understanding of both the care plan and wider system navigation.	✗ Understanding is assumed from a nod or silence, with no active verification.
✓ Concrete, translated navigation guidance is provided, covering the system beyond this one clinic.	✗ Patients understand their specific care but not how the wider health system actually functions.
✓ Plain language is used consistently, especially when working through an interpreter.	✗ Medical jargon is used routinely, straining both interpretation and comprehension.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Teach-back is used for major treatment decisions but not extended to system-navigation information.**
Understanding how to actually use the system matters as much as understanding the immediate care plan, especially for a first-contact patient.

2 **System literacy support is given verbally but not reinforced with anything the patient can review later.**
Complex system information delivered once, verbally, under stress is easily forgotten.

3 **Staff assume system literacy for patients registered for a while, missing gaps that may still exist.**
Length of registration does not reliably correlate with genuine system understanding.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Observe current practice for both understanding-verification and system-navigation support.

Week 2 Train staff on teach-back technique and develop translated navigation guidance.

Week 3 Brief staff to proactively cover system literacy alongside the immediate clinical matter.

Ongoing Spot-check patient understanding of both care and system navigation periodically.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Observe an actual consultation if possible, watching specifically for teach-back covering both care and navigation.
This is a practice that is easy to describe in policy and easy to skip under time pressure.

Ask a patient directly what they understand about accessing care again, including if they relocate.
This tests actual system literacy, not just satisfaction with the immediate visit.

E-LEARNING academy.gmj.ge/phc-std8-2-understanding-and-navigation — 30 min · complete before self-assessment

Standard 8.3 **NON-NEGOTIABLE** · *Standard 8: Health & Migration*

Language and Communication Aids — Interpreters and Cultural Mediators

ASSESSMENT ASF-PHC-STD8-v3.0

CR FULL	TR FULL	SM ADAPTED	ST FULL

8.3
NON-NEGOTIABLE
L1

THE STANDARD

Language and Communication Aids — Interpreters and Cultural Mediators

Trained interpreters or cultural mediators are engaged for language-discordant consultations — never minor children, and only family members when genuinely no other option exists and the situation is not high-risk.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Are trained interpreters or cultural mediators engaged for language-discordant consultations?** *Not ad hoc bilingual staff or family members as the default.* Doc: Interpreter engagement record	YES	PARTIAL	NO
2	**Is a minor ever used to facilitate interpretation for a family member?** *This should never happen — a specific, absolute rule, not a judgement call.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**When a family member interprets due to genuine unavailability of a trained interpreter, is this reserved for low-risk situations only?** *Not used for informed consent, complex diagnoses, or bad news — situations WHO specifically flags as requiring professional language support.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Interpreter engagement review*	Reviews records for evidence of trained interpreter or cultural mediator engagement.
ASK *Minor-interpreter policy check*	Asks staff directly whether minors are ever used to interpret, and confirms understanding that this is never acceptable.
OBSERVE *High-risk situation check*	Checks whether family-member interpretation, where it occurs, is confined to genuinely low-risk situations, never consent or bad news.

REFERENCES

[38] WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

Standard 8.3 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-PHC-STD8-v3.0

WHY THIS STANDARD EXISTS

Family members interpreting, especially minors, carries real, well-documented risks — inaccurate interpretation, withheld or distorted information, compromised confidentiality, and trauma to the family member themselves. This is one of the clearest, most specific safeguards in the entire WHO framework, and it exists because the alternative genuinely and measurably harms patients.

The evidence: [38] WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Trained interpreters or cultural mediators are the default for language-discordant consultations. ✓ Staff confirm, without hesitation, that minors are never used to interpret. ✓ Family-member interpretation, when it happens, is reserved for genuinely low-risk situations only.	✗ Ad hoc bilingual staff or family members are the default, with trained interpreters rarely engaged. ✗ A minor has been used to interpret, even occasionally. ✗ Family members interpret for high-risk situations like informed consent or bad news.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Trained interpreters are used for major appointments but family members fill in for quick or informal interactions.**
Risk doesn't scale down proportionally with how brief or informal an interaction feels.

2 **The no-minors rule is understood by the physician but not consistently reinforced with the limited support staff available.**
A critical safeguard needs to be embedded across the whole small team, not held only by the physician.

3 **Interpreter access exists during clinic hours but reverts to family members for same-day or urgent visits.**
Coverage gaps at specific times undermine an otherwise sound policy.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review recent language-discordant consultations for interpreter engagement patterns.

Week 2 Establish reliable access to professional interpretation, including remote or telephone options where in-person isn't feasible.

Week 3 Brief all staff, however few, on the firm exclusion of children as interpreters, without exception.

Ongoing Audit interpreter use records for consistency.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff directly whether a child has ever interpreted for a parent here.
A direct question often surfaces what a general policy question won't.

Observe an actual encounter with a limited-proficiency patient if timing allows.
Direct observation reveals whether professional interpretation is genuine practice, not just stated policy.

E-LEARNING academy.gmj.ge/phc-std8-3-language-cultural-mediators — 30 min · complete before self-assessment

Standard 8.4 **CORE** · *Standard 8: Health & Migration*

Collaborative Practice Across Health and Social Services

ASSESSMENT ASF-PHC-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.4
CORE
L1

THE STANDARD

Collaborative Practice Across Health and Social Services

The practice actively engages with legal, social, and community support services relevant to refugee and migrant patients, and conducts effective handover of care that includes migration- and displacement-related context — not treating primary care as isolated from these interconnected factors.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Does the practice actively engage with relevant social support services, not treat health care in isolation?** *Genuine, active engagement, not a general awareness that such services exist.* Doc: Social services engagement record	YES	PARTIAL	NO
2	**Does handover to another provider specifically include migration- and displacement-related context?** *Specific inclusion of this context, not a generic clinical handover.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Are staff aware of specific local services relevant to this population, not just services generally?** *Specific, current knowledge, not a vague sense that support services exist somewhere.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
DOCUMENT *Social services engagement review*	Reviews evidence of active engagement with relevant social support services.
DOCUMENT *Handover content review*	Reviews handover documentation for specific inclusion of migration-related context.
ASK *Local services knowledge interview*	Asks staff to name specific local services relevant to refugee and migrant patients.

REFERENCES

[39] WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

Standard 8.4 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-PHC-STD8-v3.0

WHY THIS STANDARD EXISTS

Housing, legal status, and social support don't just sit alongside a refugee or migrant patient's health — they actively shape it, and a practice that treats health in isolation from these factors, or that fails to hand over migration-related context when referring elsewhere, misses information a purely clinical view wouldn't capture.

The evidence: [39] WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The practice actively, genuinely engages with relevant social support services.	✗ Health care is treated in isolation from social support factors.
✓ Handover to other providers specifically includes migration-related context.	✗ Handover is generic, omitting migration-related context.
✓ Staff can name specific, current local services relevant to this population.	✗ Staff have no specific knowledge of relevant local services.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Engagement happens with legal services but not consistently with housing or employment support.**
Each of these factors can independently and significantly affect a patient's health.

2 **Referral to specialist care includes clinical information but omits migration-related context that shaped the initial presentation.**
The receiving provider benefits from the same contextual understanding this practice relied on.

3 **Staff know general categories of support exist but not specific, current local contacts.**
Specific, current knowledge is what makes a referral actually actionable for the patient.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Map current engagement with relevant social support services.

Week 2 Establish or strengthen specific, current local service contacts.

Week 3 Build migration-related context into standard referral and handover documentation.

Ongoing Refresh knowledge of local services periodically as availability changes.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to name a specific local service they would refer a patient to, not a general category.
Specificity reveals genuine, current knowledge rather than assumed awareness.

Review a real referral document for migration-related context inclusion.
A real example reveals whether this happens in practice, not just in policy.

E-LEARNING academy.gmj.ge/phc-std8-4-collaborative-practice — 30 min · complete before self-assessment

Standard 8.5 **NON-NEGOTIABLE** · *Standard 8: Health & Migration*

A Comprehensive Initial Health Assessment Screens for the Documented Triple Burden

ASSESSMENT ASF-PHC-STD8-v3.0

CR ADAPTED	TR FULL	SM FULL	ST FULL

8.5
NON-NEGOTIABLE
L1

THE STANDARD

A Comprehensive Initial Health Assessment Screens for the Documented Triple Burden

Every newly registered refugee or migrant patient receives a comprehensive initial health assessment screening for the documented triple burden — infectious disease, non-communicable disease, and mental health — not a narrow, single-issue check that misses the other two dimensions of this well-established pattern.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does every newly registered refugee or migrant patient receive a comprehensive initial health assessment?** *A real, comprehensive assessment, not a narrow check limited to one presenting concern.* Doc: Initial health assessment record	YES	PARTIAL	NO
2	**Does this assessment genuinely cover all three dimensions of the triple burden — infectious disease, non-communicable disease, and mental health?** *Genuine coverage of all three, not one or two dimensions while the others go unaddressed.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Does the assessment include catch-up vaccination review, not assumed current without checking?** *Real, active vaccination status review, not assumed adequacy.* Doc: Catch-up vaccination review record	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Initial assessment completeness review*	Reviews initial health assessments for genuine coverage of all three triple-burden dimensions.
DOCUMENT *Vaccination review check*	Reviews whether catch-up vaccination status is actively assessed as part of initial screening.
ASK *Assessment practice interview*	Asks staff how the initial assessment for a newly registered refugee or migrant patient genuinely covers all three dimensions.

REFERENCES

[40] Refugees are consistently described as facing a documented "triple burden" of infectious disease, non-communicable disease, and mental health issues, with integrated multi-disease screening at first primary care contact shown to achieve better uptake and feasibility than single-disease screening approaches, despite most health systems still lacking systematic implementation.

Standard 8.5 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-PHC-STD8-v3.0

WHY THIS STANDARD EXISTS

Refugees and migrants are consistently, disproportionately affected by infectious disease, non-communicable disease, and mental health difficulty simultaneously, and evidence specifically shows integrated, multi-condition screening at first contact achieves meaningfully better uptake than single-disease screening — yet most systems still fail to implement this systematically, leaving genuine, documented needs unidentified at exactly the point they could first be caught.

The evidence: [40] Refugees are consistently described as facing a documented "triple burden" of infectious disease, non-communicable disease, and mental health issues, with integrated multi-disease screening at first primary care contact shown to achieve better uptake and feasibility than single-disease screening approaches, despite most health systems still lacking systematic implementation.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Every newly registered patient receives a genuinely comprehensive initial assessment.	✗ Initial assessment is narrow, addressing only the immediate presenting concern.
✓ The assessment covers all three triple-burden dimensions, not a narrow subset.	✗ Only one or two triple-burden dimensions are covered, missing the others.
✓ Catch-up vaccination status is actively reviewed as part of the assessment.	✗ Vaccination status is assumed current without active review.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Infectious disease and vaccination screening are thorough but mental health screening is less consistently included.**
Mental health is a genuine, documented part of the triple burden, not a secondary consideration.

2 **The assessment is comprehensive when time allows but abbreviated during busy periods.**
A newly arrived patient's genuine need for this assessment doesn't diminish because the clinic is busy that day.

3 **Screening happens but isn't specifically adapted to the patient's actual country of origin and risk profile.**
Genuine risk-appropriate screening reflects the patient's real background, not a generic checklist.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current initial assessment practice for genuine coverage of all three triple-burden dimensions.

Week 2 Build a structured, comprehensive initial assessment protocol including vaccination review.

Week 3 Train staff on country-of-origin-appropriate risk screening.

Ongoing Audit initial assessment completeness for newly registered patients.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask to see a specific, real initial assessment and check for genuine coverage of all three dimensions.
A real, specific example reveals whether this is genuine practice, not policy language.

Ask how the assessment is adapted for a patient's specific country of origin.
A specific, informed answer reveals genuine, risk-appropriate practice, not a generic checklist.

E-LEARNING academy.gmj.ge/phc-std8-5-initial-health-assessment — 30 min · complete before self-assessment

Standard 8.6 **CORE** · *Standard 8: Health & Migration*

Evidence-Informed Care for Refugee and Migrant Populations

ASSESSMENT ASF-PHC-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.6
CORE
L1

THE STANDARD

Evidence-Informed Care for Refugee and Migrant Populations

Staff use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain — not applying general primary care guidelines uncritically to a population with documented, different health needs.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Are staff aware of evidence-informed guidelines specific to refugee and migrant health where they exist?** *Specific, current awareness, not general clinical knowledge assumed to be sufficient.* Doc: Guideline awareness record	YES	PARTIAL	NO
2	**Do staff recognise where this population's health needs genuinely differ from the general population?** *Genuine, specific recognition, not an assumption that general guidelines always apply equally.* Doc: N/A — tested directly	YES	PARTIAL	NO
3	**Is practice adapted where population-specific evidence indicates a different approach is warranted?** *Actual practice adaptation, not awareness without application.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

DOCUMENT *Guideline awareness review*	Reviews whether staff have access to and awareness of population-specific evidence-informed guidelines.
ASK *Population-difference interview*	Asks staff to describe a specific way this population's health needs differ from the general population.
OBSERVE *Practice adaptation check*	Checks whether practice genuinely reflects population-specific evidence where it exists.

REFERENCES

[41] WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

Standard 8.6 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-PHC-STD8-v3.0

WHY THIS STANDARD EXISTS

Refugee and migrant health needs genuinely differ from the general population in ways that matter clinically, and care that ignores this and applies general guidelines uncritically can miss real, evidence-based adjustments this specific population needs.

The evidence: [41] WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff are aware of and use population-specific evidence-informed guidelines where they exist.	✗ General population guidelines are applied uncritically with no population-specific awareness.
✓ Staff can describe specific, genuine differences in this population's health needs.	✗ Staff cannot describe any specific way this population's needs differ.
✓ Practice is genuinely adapted where population-specific evidence indicates it should be.	✗ Awareness exists but doesn't translate into any actual practice adaptation.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Awareness exists for well-known differences but not for more specific or recent evidence.**
Evidence in this area continues to develop, and awareness needs to stay genuinely current.

2 **Guidelines are known but not consistently applied under time pressure.**
Consistent application under real conditions is what gives awareness genuine protective value.

3 **Evidence gaps are acknowledged but staff default to general population assumptions rather than flagging genuine uncertainty.**
Recognising a genuine gap honestly is different from silently defaulting to a possibly inapplicable assumption.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current awareness of population-specific evidence-informed guidelines.

Week 2 Establish access to current, relevant guidelines for staff.

Week 3 Train staff on specific, genuine population differences relevant to practice.

Ongoing Refresh awareness as evidence in this area develops.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff for a specific example of a practice adaptation based on population-specific evidence.
A real example reveals genuine application, not just familiarity with the concept.

Ask how staff would handle a genuine evidence gap for this population.
A thoughtful, honest answer reveals genuine engagement rather than a default assumption.

E-LEARNING academy.gmj.ge/phc-std8-6-evidence-informed-care — 30 min · complete before self-assessment

Standard 8.7 **NON-NEGOTIABLE** · *Standard 8: Health & Migration*

Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts

ASSESSMENT ASF-PHC-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.7
NON-NEGOTIABLE
L1

THE STANDARD

Staff Reflective Practice, Bias Awareness, and Self-Care in Migration Contexts

Staff maintain active awareness of their own culture, beliefs, and potential biases through structured reflective practice, and the practice actively fosters a supportive environment with genuine access to psychological support — not assumed self-awareness or an assumption that staff will manage vicarious trauma exposure on their own.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the practice have a structured process for staff reflective practice regarding bias and cultural awareness?** *A defined process, not an assumption that staff will naturally self-reflect adequately.* Doc: Reflective practice process description	YES	PARTIAL	NO
2	**Does the practice provide genuine, accessible psychological support and a real space to discuss difficult cases?** *Actual, used support and a real, regular opportunity, not a theoretical benefit or informal hope.* Doc: Psychological support access record	YES	PARTIAL	NO
3	**Can staff describe a specific instance of adapting their practice after recognising a bias, and do they recognise signs of vicarious trauma in themselves?** *Genuine, concrete examples, not general statements of good intentions or awareness.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Reflective practice process review*	Reviews the practice's structured process, if any, for staff reflective practice on bias and cultural awareness.
DOCUMENT *Support access review*	Reviews what psychological support and debrief structure genuinely exist and whether they are actually used.
ASK *Staff example interview*	Asks a staff member for a specific instance of recognising and adapting for their own bias, and how they process the emotional weight of this work.

REFERENCES

[42] WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

Standard 8.7 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-PHC-STD8-v3.0

WHY THIS STANDARD EXISTS

Unacknowledged bias shapes clinical judgement in ways that are genuinely hard to see from the inside, and staff providing this care are regularly exposed, secondhand, to accounts of hardship and trauma — both are real, documented occupational realities of this work, and both require structured, deliberate support rather than being left to individual capacity alone, even in a very small practice.

The evidence: [42] WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ A structured reflective practice process genuinely exists and is used, not just assumed.	✗ No structured reflective practice process exists beyond an assumption of individual self-awareness.
✓ Genuine, accessible psychological support exists and staff actually use it.	✗ Psychological support exists only nominally, with no evidence staff actually access it.
✓ Staff can describe specific, real examples of both bias adaptation and vicarious trauma awareness.	✗ Staff cannot describe any specific example of adapting practice or recognising vicarious trauma.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Reflective practice happens informally but is not structured into any genuine, regular process.**
Individual good practice does not reliably generalise without a defined, shared process, even at small scale.

2 **Support exists but is genuinely difficult to access given the demands of a very small practice.**
A benefit's existence does not guarantee genuine, comfortable access to it, particularly for a solo practitioner.

3 **Support exists for acute incidents but not for the cumulative emotional weight of this work over time.**
Cumulative impact deserves the same genuine support as acute incidents.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current training content and support access for genuine coverage of bias and staff wellbeing.

Week 2 Establish a structured reflective practice process feasible for the practice's actual size.

Week 3 Identify genuine, accessible psychological support options appropriate to solo or small practice.

Ongoing Revisit reflective practice and wellbeing periodically, using real case examples where appropriate.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a specific personal example, not a general statement of awareness.
A concrete instance distinguishes genuine reflective practice from familiarity with the concept.

Ask directly whether support has been used, not just whether it exists.
Genuine uptake, not nominal availability, is the real test.

E-LEARNING academy.gmj.ge/phc-std8-7-reflective-practice-and-self-care — 30 min · complete before self-assessment

Standard 8.8 **CORE** · *Standard 8: Health & Migration*

Continuity Across Relocation Is Actively Supported, Not Assumed Impossible

ASSESSMENT ASF-PHC-STD8-v3.0

CR N/A	TR FULL	SM ADAPTED	ST FULL

8.8
CORE
L1

THE STANDARD

Continuity Across Relocation Is Actively Supported, Not Assumed Impossible

When a refugee or migrant patient relocates, the practice actively supports genuine continuity of their care — a portable, patient-held summary, active handover where a new provider is known — not treating relocation as an automatic, unavoidable end to any continuity at all.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.

1	**Does the practice actively support continuity when a patient relocates, not treat relocation as an automatic end to continuity?** *Real, active support, not passive acceptance that continuity simply ends.* Doc: Relocation continuity support process	YES	PARTIAL	NO
2	**Is a portable, patient-held summary genuinely provided, giving the patient something to carry forward?** *A real, usable summary the patient actually holds, not information that stays only in this practice's own records.* Doc: Patient-held summary documentation	YES	PARTIAL	NO
3	**Where a new provider is known, is active handover genuinely attempted, not assumed impossible?** *A real, attempted handover, not an assumption that contact with a future provider isn't achievable.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks

DOCUMENT *Relocation support process review*	Reviews the practice's actual process for supporting continuity when a patient relocates.
DOCUMENT *Patient-held summary review*	Reviews whether patients genuinely receive a portable, usable summary of their care.
ASK *Handover attempt interview*	Asks staff whether they've genuinely attempted handover to a new provider when one becomes known.

REFERENCES

[43] Continuity of care as genuine infrastructure, distinct from an assumption that relocation automatically ends the possibility of continuity, is established practice for protecting health outcomes in mobile and displaced populations specifically.

Standard 8.8 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-PHC-STD8-v3.0

WHY THIS STANDARD EXISTS

Refugee and migrant populations move more frequently than the general population, often for reasons entirely outside their control, and this document's whole foundation rests on genuine continuity of care — a practice that treats relocation as simply ending that continuity, rather than actively supporting it across the move, abandons exactly the patients most likely to need it preserved.

The evidence: [43] Continuity of care as genuine infrastructure, distinct from an assumption that relocation automatically ends the possibility of continuity, is established practice for protecting health outcomes in mobile and displaced populations specifically.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ The practice actively supports continuity when a patient relocates.	✗ Relocation is treated as an automatic, unavoidable end to continuity.
✓ A genuine, portable, patient-held summary is provided.	✗ No patient-held summary is provided; information stays only in this practice's records.
✓ Active handover is genuinely attempted when a new provider becomes known.	✗ No handover is attempted, even when a new provider is known.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **A summary is provided but isn't updated close to the point of relocation, so it quickly becomes outdated.**
A summary's real value depends on reflecting the patient's genuinely current status at the time they carry it forward.

2 **Handover is attempted when the new provider is known well in advance but not for sudden, unplanned relocations.**
Sudden relocation doesn't reduce a patient's genuine need for continuity support.

3 **Support exists in principle but staff aren't confident in how to actually provide a portable summary in practice.**
A principle without practical, confident execution provides limited real protection.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for genuine continuity support versus assumed end at relocation.

Week 2 Establish a standard, portable patient-held summary format.

Week 3 Train staff on attempting genuine handover when a new provider becomes known.

Ongoing Confirm summaries are updated close to the actual point of relocation.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask for a real, recent example of continuity support provided to a relocating patient.
A real example reveals whether this is genuine practice, not an assumed impossibility.

Ask to see an actual patient-held summary and check how current it genuinely is.
A specific, current document is the real evidence of genuine support, not a stale or theoretical one.

E-LEARNING academy.gmj.ge/phc-std8-8-relocation-continuity — 30 min · complete before self-assessment

Standard 8.9 **CORE** · *Standard 8: Health & Migration*

Legal Status Diversity Recognition

ASSESSMENT ASF-PHC-STD8-v3.0

CR FULL	TR FULL	SM FULL	ST FULL

8.9
CORE
L1

THE STANDARD

Legal Status Diversity Recognition

The practice can name which legal status categories it actually serves — asylum seeker, recognised refugee, stateless person, and others — and demonstrates it doesn't apply a single, uniform assumption about access rights across all of them.

CLINIC SELF-ASSESSMENT **Tick YES, PARTIAL, or NO for each question.**

1	**Can staff name the specific legal status categories this practice actually serves?** *Specific, named categories, not a general sense that "migrants" are served.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Does the practice avoid applying a single, uniform assumption about access rights across all statuses?** *Genuine differentiation, not treating all categories identically.* Doc: Status-specific access policy documentation	YES	PARTIAL	NO
3	**Is there a specific process for verifying which category applies when it's genuinely unclear?** *A real, defined process, not guesswork or assumption when status is ambiguous.* Doc: Status verification process	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Requires improvement plan.

WHAT THE ASSESSOR DOES ON SITE **no surprises, no hidden checks**

ASK *Status category awareness interview*	Asks staff to name the specific legal status categories this practice actually serves.
DOCUMENT *Status-specific policy review*	Reviews documentation for genuine differentiation across status categories, not a uniform assumption.
DOCUMENT *Verification process review*	Reviews the process for verifying status when it's genuinely unclear.

REFERENCES

[44] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

Standard 8.9 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-PHC-STD8-v3.0

WHY THIS STANDARD EXISTS

Asylum seeker, recognised refugee, and stateless person are not interchangeable categories — they carry genuinely different legal access rights in different countries, and treating them as one undifferentiated group risks either wrongly denying care someone is entitled to, or missing a specific vulnerability tied to a particular status.

The evidence: [44] WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Staff can name the specific legal status categories this practice actually serves.	✗ Staff have only a general sense that "migrants" are served, without specific categories.
✓ Policy genuinely differentiates access considerations across status categories.	✗ A single, uniform assumption about access rights is applied regardless of status.
✓ A specific, defined process exists for verifying unclear status.	✗ No process exists for verifying status when it's genuinely unclear.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **Staff can name the most common category served but not less frequent ones the practice still encounters.**
Even infrequent categories deserve genuine, specific awareness, not the risk of misapplied assumptions.

2 **Differentiation exists in the physician's own understanding but isn't shared with the wider practice team.**
Every staff member interacting with patients benefits from the same genuine understanding.

3 **A verification process exists but staff are inconsistently confident applying it.**
A process needs genuine staff familiarity to function reliably under real conditions.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current staff awareness of the specific legal status categories actually served.

Week 2 Build specific, differentiated access guidance for each relevant status category.

Week 3 Establish a clear verification process for genuinely unclear status.

Ongoing Refresh staff awareness periodically, particularly for less frequently encountered categories.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask staff to name every specific legal status category the practice has served recently.
Specificity reveals genuine, current awareness rather than a general assumption.

Ask what happens when a patient's specific status is genuinely unclear.
A confident, specific answer reveals a genuine process, not improvisation.

E-LEARNING academy.gmj.ge/phc-std8-9-legal-status-recognition — 30 min · complete before self-assessment

	Standard 8.10 NON-NEGOTIABLE · *Standard 8: Health & Migration* **Care Is Documented and Provided Regardless of Immigration or Legal Status**	ASSESSMENT ASF-PHC-STD8-v3.0
CR FULL	TR FULL	SM FULL	ST FULL

8.10
NON-NEGOTIABLE
L1

THE STANDARD

Care Is Documented and Provided Regardless of Immigration or Legal Status

Care is provided and fully documented for every patient regardless of immigration or legal status, with no differential standard of care, documentation practice, or record-keeping applied based on status — not a lesser or informal standard applied to patients without documented status.

CLINIC SELF-ASSESSMENT Tick YES, PARTIAL, or NO for each question.				
1	**Is the same standard of care applied and documented the same way regardless of a patient's immigration or legal status?** *Genuinely equal treatment, not a lesser or informal standard for undocumented patients.* Doc: N/A — tested directly	YES	PARTIAL	NO
2	**Are staff specifically trained that immigration status is never a reason to withhold or alter care or documentation?** *Specific, documented training, not assumed understanding.* Doc: Staff training record	YES	PARTIAL	NO
3	**Is patient information protected with the same confidentiality standard regardless of status, with no informal sharing of status-related information?** *The same confidentiality protection extended to every patient, without exception.* Doc: N/A — tested directly	YES	PARTIAL	NO

ALL YES Standard likely met. **ANY PARTIAL** Improvement plan required. **ANY NO** Blocks accreditation until resolved.

WHAT THE ASSESSOR DOES ON SITE no surprises, no hidden checks	
OBSERVE *Care standard observation*	Observes whether care and documentation practice is genuinely consistent regardless of patient status.
DOCUMENT *Staff training review*	Reviews training records confirming staff understand immigration status is never a basis for differential care.
ASK *Confidentiality practice interview*	Asks staff how patient status information, where known, is protected.

REFERENCES

[45] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

Standard 8.10 · *Standard 8: Health & Migration*

Guidance & Learning

GUIDANCE ASF-PHC-STD8-v3.0

WHY THIS STANDARD EXISTS

A patient who fears that seeking care will expose their immigration status to consequences may delay or avoid care entirely, and any indication that this practice applies a different standard based on status only reinforces that fear — genuine equal treatment, documented the same way for everyone, is what makes primary care genuinely accessible to this population.

The evidence: [45] Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

WHAT GOOD LOOKS LIKE	WHAT FAILURE LOOKS LIKE
✓ Care and documentation are genuinely consistent regardless of status.	✗ Care or documentation practice differs based on a patient's known or assumed status.
✓ Staff are specifically trained on this principle, not assumed to understand it.	✗ No specific training addresses this principle.
✓ Confidentiality protection is applied equally without exception.	✗ Status-related information is handled less carefully than other confidential information.

MOST COMMON REASONS CLINICS SCORE PARTIAL

1 **The principle is understood by the physician but not consistently by administrative or reception staff.**
A patient's first interaction is often with administrative staff, where the same principle needs to hold.

2 **Care is consistent but documentation habits vary informally based on individual staff assumptions.**
Consistency needs to extend to documentation practice specifically, not only the clinical care itself.

3 **The principle is followed but has never been specifically, formally trained.**
Informal understanding is less reliable than specific, documented training, particularly as staff turn over.

HOW TO IMPLEMENT IF YOU ARE STARTING FROM ZERO

Week 1 Review current practice for any differential treatment based on status.

Week 2 Establish specific staff training on this principle, covering all staff, not only clinical roles.

Week 3 Confirm documentation practice is genuinely consistent regardless of status.

Ongoing Reinforce training periodically, particularly for new staff.

FOR SURVEYORS — WHAT IS NOT OBVIOUS

Ask administrative staff, not only the physician, about this principle.
This reveals whether the principle genuinely extends beyond clinical staff.

Ask how patient status information, where it becomes known, is protected.
A specific, confident answer reveals genuine practice, not just a stated value.

E-LEARNING academy.gmj.ge/phc-std8-10-status-neutral-care — 30 min · complete before self-assessment

References

Numbered references below are formal citations, in Vancouver style, each individually verified against the original source before inclusion. The [N] marker on each criterion's Reference line and "The evidence" line corresponds to its number here.

1. Empanelment is the act of assigning individual patients to individual primary care providers and care teams with sensitivity to patient and family preference, and is established as the basis for population health management and therapeutic continuity in primary care practice.

2. Retrospective analysis of linked health administrative data found continuity of care with an individual family physician is associated with reduced emergency department visits and hospitalizations across varying levels of patient complexity, establishing relational continuity as a mechanism with genuine, measurable clinical benefit.

3. The Usual Provider of Care Index, defined as the proportion of a patient's visits with their own designated primary care provider, is an established, validated metric for measuring genuine continuity of care in primary care practice.

4. Comprehensive intake capturing chronic conditions, family history, and social context, distinct from administrative registration alone, is established practice in primary care literature as foundational to effective population health management and individualized care.

5. A genuine, defined pathway for patients to reach their own assigned clinician or care team, distinct from default routing to any available provider, is established practice for preserving the real value of primary care continuity.

6. Research estimates that delivering all recommended preventive services for a standard patient panel would require approximately 14.1 hours per day on top of acute and chronic disease care, with surveyed primary care providers reporting they prioritize only one to three preventive services per visit due to time constraints.

7. Established evidence-graded preventive service recommendation systems identify high-priority services as those with high or moderate net benefit for eligible patients, recognized in various forms across many countries' preventive care guidance.

8. National data from multiple countries document a persistent gap between long-established, high-priority screening recommendations and actual completion rates, demonstrating that completion rates require active measurement rather than assumed adequacy.

9. Established evidence-graded preventive service guidance recommends annual lung cancer screening for eligible patients based on sufficient evidence of net benefit, while specifically requiring a thorough process of informed and shared decision-making prior to screening given the genuine tradeoffs between benefits and harms involved.

10. Systematic immunization tracking against current recommended schedules, with active identification and closure of gaps, is established practice in primary care preventive medicine, distinct from reliance on unprompted patient request or assumed currency.

11. Patients with diabetes require access to systematic and ongoing care delivered by a team of healthcare providers, with registry-based tracking established as foundational to achieving national quality benchmarks for chronic disease control in primary care.

12. Documented national health data has found a persistent gap between the proportion of patients diagnosed with a chronic condition such as hypertension and the proportion with confirmed, documented control, establishing specific, measured control — not assumed improvement — as the genuine standard for chronic disease management quality.

13. Established diabetes quality improvement practice specifically includes a process to identify and proactively reach out to patients with poor glycemic control who have not had a test in more than four months, rather than waiting for the patient to independently schedule follow-up.

14. Meta-analysis of team-based chronic disease care found that compared with usual care, team-based approaches involving patients, primary care providers, and additional healthcare professionals such as nurses or pharmacists were associated with greater reductions in blood glucose levels and greater improvements in blood pressure and lipid control.

15. A hypertension management program that included evidence-based practice guidelines for pharmacological treatment adjustment and defined follow-up after medication changes was associated with measurably improved hypertension control rates, establishing a defined adjustment process, distinct from unchanged treatment, as genuinely effective practice.

16. Established urgent care red flag policy requires that staff responsible for patient intake, not only the treating provider, be able to recognise defined red flag signs and symptoms and immediately take the patient to a space kept ready for emergencies, so there is no delay in care.

17. A substantial majority of primary and urgent care activity in many health systems consists of patients requesting same-day services, establishing genuine same-day access as a core, high-volume function of primary care requiring active measurement, not passive assumption of adequacy.

18. Structured telephone triage protocols for patients requesting same-day primary care appointments are established, evidence-based practice, distinct from unstructured individual judgement, with research demonstrating their effectiveness in managing primary care workload while maintaining patient safety.

19. Structured approaches to red flag identification are established as necessary in primary care because a substantial number of serious conditions present with atypical or nonspecific symptoms resembling benign, self-limiting illness, requiring genuine differentiation rather than default assumption of the more common explanation.

20. Dedicated space, ready emergency equipment, and defined staff roles for a deteriorating patient, distinct from improvised response, are established practice in urgent and primary care safety policy for managing genuine on-site emergencies.

21. An analysis of over 100,000 referral scheduling attempts in a large health system found only 34.8 percent resulted in documented completed specialist appointments, establishing active tracking to completion, distinct from assumed follow-through, as essential to closing the referral loop.

22. Institute for Healthcare Improvement, National Patient Safety Foundation. Closing the Loop: A Guide to Safer Ambulatory Referrals in the EHR Era. Cambridge, MA: IHI; 2017 — establishes a standardized, nine-step closed-loop process requiring specialist findings to be communicated back to the referring clinician through appropriate channels within a defined timeframe.

23. Research into primary care and specialist referral handoffs identifies ambiguous responsibility for coordinating patient care as a specific, documented area of breakdown, distinct from individual clinician failure, arising when no single role is explicitly assigned ownership of a given step.

24. High variation in specialist wait times, correlated with lower documented appointment completion rates, is identified in referral system research, establishing that urgency-differentiated tracking, not uniform process application, is necessary to protect genuinely time-sensitive referrals.

25. Research into referral process breakdowns identifies the gap between initial patient contact and actual appointment scheduling as the most common failure point, establishing active patient support through this specific stage as necessary to prevent referrals from being lost.

26. Research on test result communication found that while automated notification systems statistically improved confirmed acknowledgement of test results, there was no corresponding improvement in documented actions taken in response, establishing that tracking to genuine action, not receipt alone, is necessary for real patient safety.

27. A study of confirmed diagnostic errors in primary care found that patient-practitioner encounter breakdowns were primarily related to problems with history-taking, in 56.3 percent of cases, examination, in 47.4 percent of cases, and ordering diagnostic tests for further work-up, in 57.4 percent of cases.

28. Preventable adverse drug events are estimated to affect approximately 2 percent of adult outpatients, with primary care clinicians, when systematically surveyed, identifying specific, addressable process gaps in prescribing, quality assurance, and patient education as the primary drivers of preventable medication error.

29. The World Health Organization has specifically called for point-of-care diagnostic methods designed to function reliably in settings with limited access to laboratory services, establishing genuine, verified accuracy — not mere availability of a testing device — as essential to the real clinical value of point-of-care testing.

30. World Health Organization data indicate that as many as 4 in 10 patients are harmed in primary and ambulatory care settings, with up to 80 percent of this harm considered avoidable, establishing the genuine, everyday clinical environment, not documentation alone, as a real determinant of patient safety.

31. Continuity of care functions as genuine infrastructure protecting both patient outcomes and the rural primary care workforce itself, establishing defined coverage arrangements, distinct from unplanned care gaps, as essential to sustaining this infrastructure specifically in solo and small rural practice.

32. Agency for Healthcare Research and Quality research found that more than one quarter of physicians in small- and medium-sized primary care practices experience moderate to severe burnout, with rural clinicians reporting the highest rates, and established that burnout measurably impairs attention, memory, and executive function with direct implications for patient safety.

33. Quality improvement initiatives adapted for solo and small primary care practices, including structured support models and micro-scale improvement projects, are established as genuinely effective and appropriate to practice size, distinct from an assumption that meaningful quality improvement requires large-scale infrastructure.

34. Structured training and competency verification, distinct from informal on-the-job learning alone, is established practice for genuine patient safety regardless of practice size, with quality improvement support models specifically developed to extend structured training support to small and solo practices.

35. Genuine review and resulting practice change following an incident, distinct from documentation alone, is established as essential to meaningful quality improvement and patient safety learning in primary care, regardless of practice size or formal committee structure.

36. WHO Competency Standard 1 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) requires health workers to adapt practice to migration and displacement experiences, address trauma-informed care and psychosocial needs, and support continuity of care regardless of legal status.

37. WHO Competency Standards 2 and 4 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to assess and support health system literacy as distinct from condition-specific understanding, and to actively verify genuine understanding through methods such as teach-back rather than assuming comprehension from silence.

38. WHO Competency Standard 3 explicitly states health workers have a responsibility not to engage minors to facilitate interpretation, given the associated significant risk, and identifies inaccuracy, information distortion, and compromised confidentiality as documented risks of family-member interpretation generally.

39. WHO Competency Standard 5 requires engagement with broader social and community support services and effective handover of care that specifically includes cultural, language, and migration- and displacement-related considerations.

40. Refugees are consistently described as facing a documented "triple burden" of infectious disease, non-communicable disease, and mental health issues, with integrated multi-disease screening at first primary care contact shown to achieve better uptake and feasibility than single-disease screening approaches, despite most health systems still lacking systematic implementation.

41. WHO Competency Standard 7 requires health workers to use evidence-informed guidelines specific to refugee and migrant health where they exist, recognise where the health needs of this population differ from the general population, and identify where evidence gaps remain.

42. WHO Competency Standards 8 and 9 (Refugee and Migrant Health: Global Competency Standards for Health Workers, 2021) require health workers to maintain structured awareness of their own biases and institutional discrimination's impact, and to engage in self-care within a supportive team environment addressing the wellbeing impacts of migration-context care.

43. Continuity of care as genuine infrastructure, distinct from an assumption that relocation automatically ends the possibility of continuity, is established practice for protecting health outcomes in mobile and displaced populations specifically.

44. WHO's Competency Standards explicitly distinguish these legal status categories throughout, noting that access to health care and legal entitlements vary meaningfully by status and by country, and that health workers need specific awareness of this rather than a single generalised assumption.

45. Equal standard of care and documentation regardless of immigration or legal status, without differential record-keeping practice, is established practice in international guidance on healthcare access for migrant and refugee populations.

Established Practice — Not Attributed to a Single Source

The statements below reflect genuine, widely recognised professional consensus — drawn from accreditation frameworks, quality improvement literature, and established clinical practice broadly — but are not attributed to one specific paper or document. They are listed here, honestly and separately from the numbered citations above, rather than assigned an invented formal reference.

Annex — ISO 9001:2015 Correlation Table

A single-place summary of every criterion's correlation to ISO 9001:2015, for anyone checking this standard's alignment without searching page by page. Criteria not listed here carry no ISO 9001:2015 correlation — this is stated honestly, not implied as a gap in the standard itself; many patient-safety and dignity criteria simply fall outside a quality-management-system standard's scope.

CRITERION	TITLE	ISO 9001:2015

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