

Primary Health Clinic Standards — Full Guide

Complete criterion-by-criterion guidance: worked examples, first steps, common mistakes, implementation plans, and Monitor verification methods for all 45 criteria.

8 standards · 45 criteria · Version 3.0

ASF STANDARDS · PRIMARY HEALTH CLINIC · STANDARD 1

Standard 1 — Patient Registration & Continuity of Care

7 criteria · 5 non-negotiable · 2 core · Version 4.0

CRITERIA IN THIS STANDARD

- 1.1 — Every Patient Is Empaneled to a Specific, Named Clinician
- 1.2 — A Patient's Own Medical History Is Actually Known and Used, Not Treated as a New Encounter Each Visit
- 1.3 — Continuity Is Actively Measured, Not Assumed
- 1.4 — Registration Captures What Actually Matters for Ongoing Care
- 1.5 — A Patient Can Reach Their Own Clinician or Care Team, Not Just Whoever Is Available
- 1.6 — Patients Are Genuinely Informed of Their Rights, Including the Right to Refuse
- 1.7 — The Comprehensive Initial Assessment Sets Real, Shared Goals

1.1 Every Patient Is Empaneled to a Specific, Named Clinician

NON-NEGOTIABLE

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.

In plain terms: Every registered patient has a named clinician or team who is responsible for their ongoing care — not 'whoever is on duty.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Continuity is the defining feature of primary care and the reason it works: a clinician who knows the patient spots the change in weight, remembers the family history, and notices what the notes do not say. Empanelment — formally assigning each patient to a named clinician or team — is the foundation of that continuity. Without it, every visit is a first visit; the patient repeats their story; preventive care is nobody's responsibility; and chronic disease drifts. Empanelment also makes measurement possible: you cannot count your diabetic patients until you know whose patients they are.

WHAT GOOD LOOKS LIKE

- Every patient is genuinely, specifically empaneled to a named clinician or team.
- Empanelment genuinely considers patient and family preference.
- Anyone can clearly identify a patient's assigned clinician without ambiguity.

COMMON FAILURE MODES

- Patients are added to a general list with no specific, accountable assignment.
- Empanelment is mechanical, with no genuine consideration of preference.
- Staff or patients are uncertain who is actually responsible for a patient's care.

WORKED EXAMPLE

IN PRACTICE

A 4-room health centre with three doctors and 6,000 registered patients.

BEFORE	Patients were seen by whichever doctor had a free slot. No patient list existed per doctor. A diabetic patient had seen all three doctors in six months; none had reviewed her HbA1c. When asked 'who is your doctor?' most patients said 'the clinic.'
ACTION	Every registered patient was assigned to one of the three doctors, balancing lists by size and complexity. The assignment is recorded in the registration system and shown on every visit screen. Patients are booked with their own doctor by default; if seen by another, that doctor's note is flagged for the named doctor's review. Each doctor received their panel list with chronic disease flags.
AFTER	The Monitor reviewed the registration system showing 100% of active patients assigned. Asked ten patients 'who is your doctor?' — nine named the correct one. Reviewed a diabetic panel list with each doctor. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask ten patients today: 'Who is your doctor here?' Count how many can name one.
2. Assign every registered patient to one clinician or team, in the system.
3. Make the named clinician the default for booking.
4. Give each clinician their panel list.

The most common mistake: Assuming a small practice has continuity automatically — three doctors in rotation is three first visits.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Empanelment record

2. Is empanelment genuinely sensitive to patient and family preference, not assigned arbitrarily? — *Genuine consideration of preference, not a mechanical assignment process alone.*

Evidence: N/A — tested directly

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Empanelment records exist but aren't consistently updated when a clinician leaves the practice.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Empanelment record review	Reviews records for a sample of patients to confirm genuine, specific empanelment.

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

A Patient's Own Medical History Is Actually

1.2 Known and Used, Not Treated as a New Encounter Each Visit

NON-NEGOTIABLE

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.

In plain terms: At each visit, the clinician actually reviews the patient's history, previous visits, and ongoing problems — it is not treated as a fresh encounter every time.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

The patient who came in with headaches three times in four months has a pattern the fourth doctor will miss unless the record is read. The medication started last visit needs checking this visit. The abnormal result from two months ago needs acting on. A visit that starts from 'what brings you in today?' with no glance at the record is a visit that will repeat tests, miss trends, and lose the thread. The record exists to be used; a problem list, a medication list, and the last visit note should be reviewed before the patient is called in.

WHAT GOOD LOOKS LIKE

- History is genuinely reviewed and actively used at each visit.
- Ongoing issues are actively tracked and followed up, not lost between visits.
- Patients don't have to repeatedly re-explain their own history.

COMMON FAILURE MODES

- Each visit is treated as a fresh encounter, relying on what the patient mentions that day.
- Ongoing issues from prior visits are lost or not followed up.
- Patients regularly find themselves re-explaining history the practice should already know.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre with an electronic record that clinicians rarely opened before consultations.

BEFORE

Consultations began with the patient's complaint. The record was opened to write, not to read. A patient's third visit for abdominal pain was treated as new; the prior two visits and a pending

	ultrasound were not noticed. Test duplication was common.
ACTION	A one-minute pre-consultation review was made standard: problem list, medication list, last visit note, pending results — displayed as a summary screen the clinician must open before the consultation screen. Consultation templates start with 'Review of ongoing issues' before 'Presenting complaint.' A monthly audit checks that the summary was opened and ongoing issues addressed.
AFTER	The Monitor reviewed 30 consultation records: all showed the summary opened and ongoing issues addressed. Observed two consultations beginning with review of the record. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Watch three consultations: does the clinician read the record before the patient speaks?
2. Create a one-screen summary: problems, medications, last note, pending results.
3. Make opening it mandatory before the consultation screen.
4. Start the consultation template with 'ongoing issues.'

The most common mistake: Opening the record to write and never to read.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: N/A — tested directly

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.*

Evidence: Ongoing issue tracking record

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Follow-up tracking exists but isn't consistently checked before the next relevant visit.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

Method	What	Detail
ASK	Patient experience interview	Asks a patient whether they feel they have to re-explain their history at each visit.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

1.3 Continuity Is Actively Measured, Not Assumed

CORE

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.

In plain terms: The practice measures what proportion of each patient's visits are with their own clinician — and acts when the number is low.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Empanelment (1.1) is the intention; continuity is the result — and it can be measured. The Usual Provider Continuity index (proportion of visits with the assigned clinician) shows whether the intention is being realised. If it is 40%, the practice has empanelment on paper and rotation in practice. Measuring it monthly, by clinician, reveals the causes: a doctor who is often absent, a booking system that does not prioritise the named clinician, patients who prefer a different doctor. Then it can be fixed. A practice that does not measure continuity does not know whether it has any.

WHAT GOOD LOOKS LIKE

- A genuine continuity measure is actively calculated, not assumed.
- The measure is reviewed regularly, not calculated once and forgotten.
- Low continuity triggers a genuine, active response.

COMMON FAILURE MODES

- No real continuity measure exists; adequacy is simply assumed.
- A measure exists but is calculated once and never revisited.
- Low continuity, if identified, produces no real response.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre that had empaneled its patients but never measured the result.

BEFORE

All patients were assigned. Nobody had checked whether they saw their assigned clinician. When the Coordinator calculated it from six months of visit data, continuity was 52% overall and 31% for one doctor who worked part-time. Patients were routinely booked with whoever was free.

ACTION

Continuity is now calculated monthly from booking data: for each patient, the proportion of visits with their named clinician; reported by clinician. The booking system was reconfigured to offer the named clinician's next slot first. Part-time doctors' panels were reduced to match their hours. A target of 70% was set.

AFTER

The Monitor reviewed six monthly continuity reports showing improvement from 52% to 74%. Reviewed the booking system configuration. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull six months of visit data. For each patient, what proportion of visits were with their named clinician?
2. Report it by clinician.
3. Configure booking to offer the named clinician first.
4. Set a target and review monthly.

The most common mistake: Assigning patients to clinicians and never checking whether they actually see them.

SELF-ASSESSMENT QUESTIONS

1. Does the practice actively calculate a real continuity measure, not assume continuity is adequate? — *A genuine, calculated measure, not an unverified assumption.*

Evidence: Continuity measurement record

2. Is this measure reviewed regularly, not calculated once and forgotten? — *Genuine, ongoing review, not a one-time calculation.*

Evidence: N/A — tested directly

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.*

Evidence: Low-continuity response record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Low continuity is identified for specific patients but a systemic pattern across the practice isn't reviewed collectively.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

1.4 Registration Captures What Actually Matters for Ongoing Care

CORE

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.

In plain terms: Registration captures what primary care actually needs — chronic conditions, family history, social circumstances, preferred language — not just name and contact details.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A registration form that asks for name, address, and phone number captures the information a billing office needs. Primary care needs more: what conditions does this patient have, what runs in the family, do they live alone, can they read, what language do they think in, what medications are they on? This is the information that makes the first consultation useful and every subsequent one safer. Captured at registration — with a structured form, in the patient's language, with help if needed — it becomes the foundation of the record. Captured never, it is reconstructed piecemeal over years of visits, or not at all.

WHAT GOOD LOOKS LIKE

- Registration genuinely captures relevant clinical and social information, not administrative details alone.
- This information actively informs the patient's early care.
- Registration information is genuinely updated as circumstances change.

COMMON FAILURE MODES

- Registration focuses only on administrative and billing information.
- Collected information isn't used to inform actual early care.
- Registration information remains static from the first visit onward.

WORKED EXAMPLE

IN PRACTICE

A 4-room health centre with a one-page registration form asking for demographics only.

BEFORE	Registration captured name, date of birth, address, phone, and insurance. Chronic conditions, medications, family history, and social circumstances were discovered — or not — in consultations. A newly registered patient with insulin-dependent diabetes was not identified as such for four months. Language needs were not recorded; interpreters were not booked.
ACTION	The registration form was extended to two pages: current conditions, current medications, allergies, family history of major conditions, living situation, occupation, preferred language, literacy, and consent for records sharing. A nurse completes it with the patient at a registration appointment. The information populates the problem list and triggers relevant flags (e.g. diabetes registry entry, interpreter booking).
AFTER	The Monitor reviewed 20 new registrations with completed extended forms and problem lists populated. Interviewed a nurse who described the registration appointment. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Read your registration form. Does it ask about conditions, medications, family history, language?
2. Extend it to two pages covering what primary care needs.
3. Complete it with a nurse at a registration appointment.
4. Use it to populate the problem list and flags.

The most common mistake: Using a registration form designed for billing to start a clinical relationship.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Registration content documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: Registration update record

COMMON REASONS FOR A PARTIAL ANSWER

- **Chronic conditions are captured well but family history is inconsistently collected.** — Family history carries real, genuine relevance for preventive care planning.
- **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.
- **Registration is thorough at the first visit but rarely revisited as a patient's life circumstances change.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

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Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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

NON-NEGOTIABLE

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.

In plain terms: A patient with an ongoing problem has a real way to reach their own clinician or team — a phone line, a message system, a callback — not just 'book with whoever is next.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Continuity does not only happen in appointments. The patient whose medication caused a side effect, whose test result was confusing, whose child's fever has changed, needs to reach the person who knows their case — quickly, without a two-week wait for the next slot. A defined route — a nurse-staffed phone line that routes to the named team, a secure message system with a response commitment, a same-day callback — keeps the relationship alive between visits. Without it, the patient calls the general line, reaches a stranger, and starts from scratch; or goes to the emergency department; or does nothing.

WHAT GOOD LOOKS LIKE

- A genuine, defined pathway lets patients reach their own clinician or team.
- Patients are genuinely aware this pathway exists.
- A structured handoff preserves relevant history when the usual clinician is unavailable.

COMMON FAILURE MODES

- Patients default to whoever is available, with no real path to their own clinician.
- Patients are unaware any specific pathway to their own clinician exists.
- No structured handoff exists, and continuity is lost when the usual clinician is out.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre with a single reception phone line and no message system.

BEFORE	Patients with a question phoned reception, who took a message for 'a doctor.' Messages went to whoever was free. Response time was unmeasured and often days. A patient with a medication side effect stopped the medication rather than wait; another went to the emergency department for a question her doctor could have answered in two minutes.
ACTION	A nurse-staffed clinical line was created, open during clinic hours, routing messages to the patient's named team with a same-day callback commitment for clinical questions. A secure patient message system was added with a 24-hour response target. Non-urgent questions are answered by the team nurse; clinical decisions by the named clinician. Response times are tracked.
AFTER	The Monitor reviewed one month of message logs: 340 contacts, 96% responded within the target; interviewed two patients who described reaching their own team. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Phone your own reception as a patient with a medication question. What happens?
2. Create a clinical line or message route to the named team.
3. Set a same-day callback commitment for clinical questions.
4. Track response times.

The most common mistake: Having only one route — the appointment — for every kind of patient need.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Patient contact pathway documentation

2. Is this pathway genuinely known to patients, not just theoretically available? — *Real, communicated awareness, not an option patients*

don't know exists.

Evidence: N/A — tested directly

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.*

Evidence: Coverage handoff protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Coverage handoff happens but relevant history isn't consistently communicated to the covering clinician.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

Method	What	Detail
DOCUMENT	Coverage handoff review	Reviews the structured handoff process when the patient's own clinician is unavailable.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

1.6 Patients Are Genuinely Informed of Their Rights, Including the Right to Refuse

NON-NEGOTIABLE

Every patient receives a genuine, understandable explanation of their rights — privacy, dignity and respect, confidentiality of their information, personal safety, how consent is granted, and the explicit right to refuse any test or treatment — not a notice buried in registration paperwork nobody actually reads. The explanation recognises the patient's cultural and spiritual preferences, including access to care consistent with them.

In plain terms: Patients genuinely know their rights — including that they can say no to a test or treatment — because someone actually told them in words they understood, not because a line was printed somewhere in the registration pack.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A small practice can feel, informally, like it doesn't need a formal rights disclosure — everyone knows everyone, the doctor is trusted, surely patients understand their rights already. But trust is not the same as genuine, verified understanding, and a patient who doesn't know they can decline a test may comply out of politeness or deference rather than genuine agreement. The right to refuse matters most exactly when a patient is uncertain or uncomfortable — precisely the moment a quiet assumption of consent is least safe. A real, spoken explanation, confirmed as understood, protects both the patient's genuine autonomy and the practice's own integrity.

WHAT GOOD LOOKS LIKE

- Every patient receives a genuine, spoken explanation of their rights, not only a form.
- Patients can describe at least one right, including the right to refuse, in their own words.
- The right to refuse is genuinely honoured, with staff able to describe the real practice.

COMMON FAILURE MODES

- Rights are disclosed only as a line in registration paperwork, never discussed aloud.
- Patients cannot describe any specific right when asked directly.
- Staff are unable to describe what actually happens when a patient declines care.

WORKED EXAMPLE

IN PRACTICE

A small practice whose rights disclosure was a single clause in the registration form.

BEFORE	New patients signed a multi-page registration packet that included, among many other clauses, a line stating patients had rights to privacy and consent. No one discussed it aloud. When interviewed, patients could not describe any specific right, and one patient said she assumed she had to accept whatever test the doctor recommended.
ACTION	The practice built a brief, spoken rights conversation delivered at the first visit — covering privacy, consent, and the explicit right to decline any test or treatment — with a simple one-page rights summary the patient keeps. Staff were trained to describe, concretely, what happens if a patient declines a recommended test.
AFTER	The Monitor asked a recently registered patient about her rights and received a confident, specific answer, including that she could decline a test without it affecting her other care. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask a recent patient what they understand their rights to be. Listen to the gap.
2. Build a brief, spoken rights conversation for the first visit, not only a form.
3. Train staff to describe, concretely, what happens when a patient declines care.

The most common mistake: Assuming a line in the registration paperwork constitutes genuine disclosure, when no patient has ever had their rights actually explained aloud or confirmed as understood.

SELF-ASSESSMENT QUESTIONS

1. Does every patient receive a genuine, understandable explanation of their rights, not just a form to sign? — *A real explanation that registers, not paperwork signed without discussion.*
Evidence: Rights disclosure process documentation

2. Can a patient asked directly describe at least one of their rights, including the right to refuse treatment, in their own words? — *Tests genuine understanding, not just that disclosure technically occurred.*

Evidence: Patient interview

3. Is the right to refuse genuinely honoured in practice, with staff able to describe what happens when a patient exercises it? — *A real, functioning right, not a line in a form with no defined practice behind it.*

Evidence: Staff interview

4. Is there a real, accessible way for a patient to request accommodation of their cultural or spiritual needs? — *A specific, usable process a patient can actually invoke, not only general staff awareness.*

Evidence: Accommodation request process

COMMON REASONS FOR A PARTIAL ANSWER

- **Rights are explained at registration but never reinforced at subsequent visits.** — A single disclosure, long ago, may not be what the patient actually remembers when it matters.
- **Consent is genuinely obtained for major procedures but not for simpler, routine tests.** — The right to refuse applies to any test or treatment, not only major interventions.
- **Staff know the policy exists but struggle to describe a real instance of a patient declining care.**

IMPLEMENTATION PLAN

When	What
Week 1	Review current rights disclosure practice for genuine, spoken explanation.
Week 2	Build a brief, spoken rights conversation and simple patient-facing summary.
Week 3	Train staff to describe concretely what happens when a patient declines care.
Ongoing	Spot-check patient understanding periodically, not only at initial registration.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
ASK	Patient interview	Asks a recently registered patient to describe at least one of their rights, including the right to refuse.
ASK	Staff interview	Asks staff to describe what actually happens when a patient declines a recommended test or treatment.

SUPERVISOR TIPS

- **Ask a patient directly whether they know they can decline a test.** — A confident, specific answer is the clearest evidence of genuine, not assumed, understanding.
- **Ask for a real, recent example of a patient declining a recommended test or treatment.** — A genuine example confirms the right functions in practice, not only on paper.

EVIDENCE BASE

World Health Organization. Patient Rights and Informed Consent in Primary Care. Geneva: WHO; 2018.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

1.7 The Comprehensive Initial Assessment Sets Real, Shared Goals

NON-NEGOTIABLE

When a patient is first empaneled, a qualified clinician performs a genuine comprehensive assessment — not only the condition that prompted the visit — drawing in other relevant disciplines where the patient's needs call for it, and sets explicit goals for their ongoing care that the patient genuinely helped shape, not goals decided for them and only announced.

In plain terms: When someone first joins the practice, a qualified clinician looks at the whole person, not just today’s complaint, brings in other specialists if the situation needs it, and together with the patient sets a real goal for their ongoing care — not a plan decided alone and handed to the patient afterward.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

A patient who comes in for a sore throat and is registered, treated, and sent home has been given episodic care, not primary care. The entire value of empanelment — the thing that distinguishes a primary health clinic from an urgent-care visit — is the comprehensive relationship behind it: knowing the whole patient, not only today’s complaint, and having a real, shared sense of what ongoing care is working toward. Skipping the comprehensive assessment at the start of that relationship means the practice never actually builds the foundation continuity is supposed to rest on, however good its day-to-day visit care might be.

WHAT GOOD LOOKS LIKE

- Empanelment includes a genuine comprehensive assessment beyond the presenting complaint.
- The assessment is performed by a qualified clinician, with other disciplines drawn in when needed.
- The patient’s record states explicit goals the patient genuinely helped set.

COMMON FAILURE MODES

- Empanelment is administrative only, with no comprehensive clinical assessment behind it.
- The assessment is completed by whoever is available, not someone verifiably qualified.
- No stated goal exists, or the goal was decided without genuine patient involvement.

WORKED EXAMPLE

IN PRACTICE

A practice where empanelment was purely an administrative registration step.

BEFORE	New patients were empaneled by filling out a registration form and seeing whichever clinician had the next available slot for their presenting complaint. No comprehensive assessment occurred, and no goal for ongoing care was ever documented — the relationship began and continued as a series of disconnected visits.
ACTION	The practice built a dedicated comprehensive assessment visit at empanelment, led by the patient's own named clinician, covering medical history, risk factors, and the patient's own priorities for their health — producing a documented goal the patient helped set, referencing other disciplines (dietitian, mental health) where relevant.
AFTER	The Monitor reviewed a newly empaneled patient's record and found a genuine comprehensive assessment and a specific, patient-involved goal, and the patient could describe that goal in their own words. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether empanelment currently includes anything beyond administrative registration.
2. Build a dedicated comprehensive assessment step, led by a qualified clinician.
3. Ask new patients directly what they want from their ongoing care, and document it as the goal.

The most common mistake: Treating empanelment as purely administrative — a name on a list — with no genuine comprehensive clinical assessment or shared goal ever actually established behind it.

SELF-ASSESSMENT QUESTIONS

1. Does empanelment include a genuine comprehensive assessment, not only a note about the presenting complaint? — *A real, broader evaluation at the start of the relationship, not only the*

specific reason for that day's visit.

Evidence: Comprehensive assessment record

2. Is the assessment performed by a genuinely qualified clinician, with other relevant disciplines drawn in where the patient's needs call for it? — *A named, qualified clinician, with real referral or consultation when complexity warrants it.*

Evidence: Assessor qualification record

3. Does the patient's record state explicit goals for their ongoing care, and was the patient genuinely involved in setting them? — *A real, stated goal and genuine involvement, not a plan decided for the patient and only communicated to them.*

Evidence: Goal documentation and patient interview

COMMON REASONS FOR A PARTIAL ANSWER

- **A comprehensive assessment happens but produces no explicitly stated goal.** — Gathering information isn't the same as using it to set a real, shared direction.
- **A goal is documented but reflects the clinician's priority, not a genuinely shared one.** — Genuine involvement means the patient's own priorities shape the goal, not only the clinician's clinical judgment.
- **The assessment happens for some patients but isn't consistently applied to every new empanelment.**

IMPLEMENTATION PLAN

When	What
Week 1	Review whether empanelment currently includes a genuine comprehensive assessment.
Week 2	Build a dedicated comprehensive assessment step at empanelment.
Week 3	Build a genuine goal-setting conversation into that assessment.
Ongoing	Audit that every newly empaneled patient has a documented, shared goal.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Comprehensive assessment review	Reviews a newly empaneled patient's record for a genuine comprehensive assessment and stated goal.
ASK	Patient interview	Asks a newly empaneled patient to describe their own stated goal for ongoing care.

SUPERVISOR TIPS

- **Pick a recently empaneled patient's file and ask for the one place that states their care goal.** — If no such place exists, the comprehensive assessment hasn't produced its intended result.
- **Ask the patient themselves what their clinician is working toward with them.** — Genuine involvement shows in whether the patient can describe their own goal.

EVIDENCE BASE

World Health Organization. Integrated People-Centred Health Services. Geneva: WHO; 2016.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Primary Health Clinic Standards — all standards**

Self-assess against these criteria →

Standard 2 — Preventive Care & Screening →

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Standard 2 — Preventive Care & Screening

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

- 2.1 — Preventive Care Is Systematically Tracked, Not Relied on From Memory
- 2.2 — Preventive Care Delivery Doesn't Depend on the Patient Remembering to Ask
- 2.3 — Screening Completion Rates Are Actively Measured and Acted On
- 2.4 — Shared Decision-Making Happens for Screening With Genuine Tradeoffs
- 2.5 — Immunization Status Is Actively Tracked and Gaps Are Closed

2.1 Preventive Care Is Systematically Tracked, Not Relied on From Memory

NON-NEGOTIABLE

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.

In plain terms: The practice has a system — a registry, a recall list, a record flag — that shows which preventive services each patient is due for, based on their age, sex, and risk. Nobody relies on memory.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A 55-year-old is due for colorectal cancer screening. A 65-year-old woman is due for a bone density scan. A smoker over 50 may be due for lung cancer screening. A child is due for a vaccine. None of this is visible in a consultation about a sore throat unless a system surfaces it. Evidence-graded preventive services — the ones with proven benefit — must be tracked systematically: for each patient, which are due, which are done, which are overdue. The system can be a register, an EHR alert, or a spreadsheet; what matters is that it exists and is used.

WHAT GOOD LOOKS LIKE

- A real, systematic tracking process identifies due preventive services for every patient.
- Tracking genuinely reflects individual age, sex, and risk factors.
- The system is actively consulted and used, not maintained separately from real care.

COMMON FAILURE MODES

- Preventive care identification relies on clinician memory during busy visits.
- Tracking is generic, not reflecting the specific patient's actual risk profile.
- A tracking system exists but isn't genuinely consulted during real encounters.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre with an EHR that had preventive care alerts switched off.

BEFORE

Preventive care happened when a clinician remembered or a patient asked. No register of who was due for what. The Coordinator audited 50 records of patients over 50: 60% had no

	documented colorectal screening; 45% of eligible women had no cervical screening recorded. Clinicians said they 'tried to remember.'
ACTION	The EHR's preventive care module was configured for grade A and B services by age and sex, with alerts at every visit. A monthly overdue report by service is generated. A nurse runs a recall list for the highest-yield services. The alerts and the report were tested against a sample of records for accuracy.
AFTER	The Monitor reviewed the alert configuration, three monthly overdue reports showing declining gaps, and 30 consultation records with alerts acted on. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pick three preventive services — cervical, colorectal, and one vaccine. Audit 30 eligible records: how many are documented?
2. Switch on or build a tracking system by age and sex.
3. Generate a monthly overdue list.
4. Assign a nurse to run recalls.

The most common mistake: Relying on clinicians to remember who is due for what — memory is not a system.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Preventive care tracking system documentation

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.*

Evidence: N/A — tested directly

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.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Tracking is reviewed for scheduled visits but not consulted during same-day or urgent encounters.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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

NON-NEGOTIABLE

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.

In plain terms: When a patient is due for a preventive service, the practice raises it — at the visit, by recall — without waiting for the patient to ask.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Patients do not know they are due for colorectal screening. They do not know their child is behind on vaccines. They do not ask. The tracking system (2.1) tells the practice; this criterion asks that the practice acts on it: the alert is seen and discussed, the recall letter is sent, the vaccine is offered at the visit for the sore throat. 'Proactively offered as a matter of routine' means the clinician raises it, the nurse raises it, or the recall system raises it — every time, not when convenient. Preventive care delivered only on request is delivered to the informed few.

WHAT GOOD LOOKS LIKE

- Grade A and B services are genuinely, proactively offered when due.
- Proactive offering happens consistently regardless of patient assertiveness or literacy.
- Real evidence shows proactive offering genuinely improves completion.

COMMON FAILURE MODES

- Preventive services are delivered only when a patient specifically asks.
- Proactive offering varies based on how informed or assertive a specific patient seems.
- No evidence connects proactive offering to genuine completion improvement.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre with tracking (2.1) in place but low completion rates.

BEFORE

Alerts appeared on the screen; clinicians dismissed them under time pressure. Recall letters went out but were not followed up. Cervical screening rate remained at 48% despite the alert system. Clinicians said 'there isn't time in a ten-minute consultation.'

ACTION

Preventive care became a nurse-led responsibility: at check-in, the nurse reviews due services, discusses them with the patient, and either delivers (vaccine, blood pressure) or schedules them before the clinician consultation. Recall letters are followed by a phone call at four

weeks. A monthly team meeting reviews the completion rates by service.

AFTER

The Monitor observed a nurse offering a due vaccine at check-in for an unrelated visit; reviewed six months of completion rates rising (cervical 48% → 71%). Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Count how many alerts were dismissed without action last month.
2. Move preventive care to the nurse at check-in.
3. Follow recall letters with a phone call.
4. Review completion rates monthly as a team.

The most common mistake: Building an alert system and letting clinicians dismiss the alerts.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Proactive offering documentation

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.*
Evidence: N/A — tested directly

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.*
Evidence: Completion rate evidence

COMMON REASONS FOR A PARTIAL ANSWER

- **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.

- **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.
- **Offering is generally consistent but staff report being less thorough during high-volume periods.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

2.3 **Screening Completion Rates Are Actively Measured and Acted On** CORE

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.

In plain terms: The practice knows its own screening completion rates — cervical, colorectal, breast, whatever applies — and has a response when a rate is low.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A rate is the difference between hoping and knowing. 'We do a lot of screening' is a feeling; '61% of eligible women had cervical screening in the last three years' is a fact that can be compared to a target, tracked over time, and improved. Measuring by service and by clinician reveals the gaps: the doctor who never raises colorectal screening; the age group that is missed; the community that does not attend. A response — a recall campaign, an outreach event, a change in approach — follows from knowing. A practice that does not measure cannot improve, and does not know whether it needs to.

WHAT GOOD LOOKS LIKE

- Real completion rates are actively measured for key screenings.
- A genuine response follows when rates are

COMMON FAILURE MODES

- Screening adequacy is assumed without genuine measurement.
- Low completion rates, if identified, produce no real

found to fall short.

- Measurement covers the full eligible panel, not only engaged patients.

response.

- Measurement only captures patients who already attend regularly, missing disengaged patients.

WORKED EXAMPLE

IN PRACTICE

A 4-room health centre serving 5,000 patients that had never calculated a screening rate.

BEFORE

Nobody knew the practice's screening rates. When the Coordinator calculated them from the register: cervical 44%, colorectal 22%, mammography 38%. All well below national targets. There had been no response because there had been no measurement.

ACTION

Screening rates are now calculated quarterly by service and by clinician from the register. Each rate has a target. Rates below target trigger a defined response: a recall campaign for that service, review with the clinician, or community outreach. The first campaign — colorectal screening kits mailed with a phone follow-up — raised colorectal screening from 22% to 51% in six months.

AFTER

The Monitor reviewed four quarterly rate reports with targets, the campaign records, and the resulting rate improvements. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Calculate your cervical, colorectal, and breast screening rates from your register today.
2. Compare each to the national target.
3. For the lowest, plan one recall campaign.
4. Recalculate quarterly.

The most common mistake: Believing screening is going well because patients who come for screening are screened — the ones who don't come are invisible.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Screening completion rate documentation

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.*

Evidence: Completion rate response record

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Measurement happens but doesn't specifically account for patients who haven't visited the practice recently.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

2.4 Shared Decision-Making Happens for Screening With Genuine Tradeoffs

NON-NEGOTIABLE

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.

In plain terms: For screening tests where the benefit is real but so is the harm — lung cancer CT, PSA, some breast screening — the patient hears both sides and decides with the clinician, not just gets a test ordered.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Not every screening test is straightforwardly good. Lung cancer CT screening saves lives in heavy smokers and generates false positives, invasive biopsies, and anxiety in many more. PSA screening detects cancers that would never have caused harm and leads to treatments that cause impotence and incontinence. For these tests, guidelines recommend shared decision-making: the clinician explains the trade-off in plain terms — how many benefit, how many are harmed — and the patient decides. Ordering the test without that conversation, or not offering it because the conversation is hard, both fail the patient. A decision aid helps; a documented conversation is the evidence.

WHAT GOOD 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.

COMMON FAILURE MODES

- 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.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre where PSA tests were ordered routinely for men over 50.

BEFORE	PSA was on the annual check-up panel for men over 50. No discussion of harms. Several men had undergone biopsies for elevated PSA; two had prostatectomies for low-grade cancer with lasting side effects; none recalled being told about over-diagnosis. Lung cancer screening was not offered because 'it's complicated.'
ACTION	PSA was removed from the routine panel. A shared decision-making protocol was written for PSA and lung cancer CT using national decision aids: the clinician presents benefits and harms in absolute numbers, the patient's values are elicited, the decision is documented — including a decision not to screen. Clinicians completed a one-hour training on the conversation. Eligible smokers are identified by the register and offered the conversation.
AFTER	The Monitor reviewed 20 records of PSA or lung screening decisions: all documented the shared decision-making conversation with the decision aid; eight documented a decision not to screen. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Check whether PSA is on your routine panel. If so, remove it.
2. Obtain national decision aids for PSA and lung cancer screening.
3. Train clinicians on the conversation — one hour.
4. Document the decision every time, including 'not to screen.'

The most common mistake: Ordering PSA routinely because it is easy — the harm from over-diagnosis is real and the patient was never asked.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Shared decision-making documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **The conversation covers benefits thoroughly but harms are mentioned only briefly.** — Genuine shared decision-making requires honest, balanced weight given to both sides.
- **Documentation shows the conversation occurred but doesn't capture what the patient actually understood.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

2.5 Immunization Status Is Actively Tracked and Gaps Are Closed

NON-NEGOTIABLE

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.

In plain terms: Every patient's vaccination status is checked against the current schedule, gaps are identified, and the practice actively closes them — not just when the patient asks.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Full	Full

WHY THIS MATTERS

Vaccination is the highest-value intervention in primary care and the one most easily neglected between the childhood schedule and old age. Adults miss tetanus boosters, pneumococcal, influenza, shingles, hepatitis B; children fall behind after a move; adolescents miss HPV. The register should show each patient's status against the schedule; every contact is an opportunity to close a gap; recalls target the overdue. Herd immunity depends on the practice reaching the patients who do not come asking.

WHAT GOOD LOOKS LIKE

- Immunization status is actively, genuinely tracked for every patient.
- Identified gaps are actively addressed, not just documented.
- Status is checked across any visit type, not only dedicated immunization visits.

COMMON FAILURE MODES

- Immunization currency is assumed without active verification.
- Gaps are noted but not actively followed through to closure.
- Status is checked only during specifically scheduled immunization visits.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre with a paediatric vaccination focus but no adult vaccination tracking.

BEFORE	Childhood vaccines were tracked by the nurse. Adults were vaccinated on request. No register of adult vaccination status. Influenza uptake in over-65s was 30%. Pneumococcal vaccination was rarely given. HPV coverage in adolescents was unknown.
ACTION	The register was configured to track vaccination status for all ages against the national schedule. Every contact includes a status check at check-in (linking to 2.2). An annual influenza and pneumococcal campaign targets over-65s and at-risk groups with recall and outreach. HPV is offered at every adolescent contact. Coverage is reported quarterly.
AFTER	The Monitor reviewed the register configuration, quarterly coverage reports (influenza in over-65s 30% → 62%), and 20 records showing gaps identified and closed at routine visits. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Calculate influenza coverage in your over-65s. Below 50% is a problem.
2. Configure your register to show vaccination status for all ages.
3. Check status at every check-in.
4. Run an annual campaign for over-65s and at-risk groups.

The most common mistake: Tracking childhood vaccines carefully and adult vaccines not at all.

SELF-ASSESSMENT QUESTIONS

1. Is immunization status actively tracked against the current recommended schedule for every patient? — *Real, active tracking, not an assumption of currency without verification.*
Evidence: Immunization tracking record
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.

Evidence: Gap closure record

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Status is checked during well-visits but not during acute or urgent encounters.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

Method	What	Detail
OBSERVE	Visit-type coverage observation	Observes whether immunization status is checked across different visit types, not only dedicated immunization visits.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Primary Health Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 1 — Patient Registration & Continuity of Care**

Standard 3 — Chronic Disease Management →

Standard 3 — Chronic Disease Management

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

- 3.1 — Chronic Conditions Are Tracked in a Registry, Not Managed Only at the Point of Visit
- 3.2 — Control Targets Are Specific and Actively Measured, Not Assumed From General Improvement
- 3.3 — Patients Overdue for Chronic Disease Follow-Up Are Proactively Identified and Contacted
- 3.4 — Team-Based Care Coordinates Chronic Disease Management
- 3.5 — Medication Adjustment Follows a Defined Process When Targets Aren't Met

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

NON-NEGOTIABLE

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.

In plain terms: Every patient with diabetes, hypertension, or another chronic condition is on an active list that the practice uses to manage them between visits — not just when they happen to come in.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

A chronic disease registry is the tool that turns a practice from reactive to proactive. Without it, the practice knows about a diabetic patient only when she attends; it cannot say how many diabetics it has, how many are controlled, how many are overdue. With it, the practice can run the list: who has not had an HbA1c in a year, who has not had a foot check, whose blood pressure is uncontrolled. The registry is the foundation for everything in this standard — targets (3.2), outreach (3.3), team care (3.4), medication adjustment (3.5). A practice that manages chronic disease only at the point of visit manages it only for patients who visit.

WHAT GOOD LOOKS LIKE

- Every chronic disease patient is genuinely entered into an active registry.
- The registry tracks status between visits, not only at the point of care.
- The registry is genuinely used to inform real care decisions.

COMMON FAILURE MODES

- Chronic conditions are managed only reactively during whatever visit occurs.
- The registry reflects only the most recent visit, with no between-visit tracking.
- A registry exists but isn't genuinely consulted in actual practice.

WORKED EXAMPLE

IN PRACTICE

A 4-room health centre with an estimated 400 diabetic patients — but no one had counted.

BEFORE

Diabetes was managed at visits. No list existed. When the Coordinator searched the records for diabetes diagnoses, 520 patients were found — 30% more than estimated. Of those, 180 had no

	HbA1c in the previous 12 months and 90 had not been seen at all. Nobody had known.
ACTION	A diabetes and hypertension registry was built from the EHR with a defined data set: last HbA1c, last BP, last foot check, last eye screening, last visit, current medications. The registry is reviewed monthly by the practice nurse, who generates outreach lists. New diagnoses are added at the point of diagnosis. Other chronic conditions (asthma, COPD, CKD) were added in phase two.
AFTER	The Monitor reviewed the registry: 520 diabetics with complete data fields; monthly review records; outreach lists with outcomes. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Search your records for every diabetes diagnosis. Count them. Compare to your guess.
2. Build a registry with the key measures for each patient.
3. Review it monthly.
4. Add hypertension, then other conditions.

The most common mistake: Managing chronic disease at visits and assuming that is the same as managing chronic disease.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Chronic disease registry documentation
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.*
Evidence: N/A — tested directly
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.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **The registry covers diabetes and hypertension well but less consistently other chronic conditions.** — Every genuine chronic condition benefits from the same systematic tracking discipline.
- **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.
- **The registry exists and is accurate but is reviewed only during scheduled chronic-care visits, not more broadly.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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

NON-NEGOTIABLE

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.

In plain terms: Chronic disease control is measured against specific evidence-based targets — HbA1c under 7%, blood pressure under 140/90 — for each patient and across the practice, not just 'getting better.'

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

'Improving' is not a target. A diabetic patient whose HbA1c has fallen from 11% to 9.5% has improved and remains poorly controlled, at high risk of complications. A target — HbA1c <7% for most adults, <8% for the frail elderly; BP <140/90; LDL <100 mg/dL for high cardiovascular risk — tells the clinician and the patient when the job is done and when it is not. Measured for each patient, targets drive treatment. Measured across the registry, they tell the practice what proportion of its diabetics are controlled — the number that matters for outcomes.

WHAT GOOD LOOKS LIKE

- Control is measured against specific, evidence-based numeric targets.
- Actual results are documented for each patient, not assumed from trend.
- The practice calculates its own genuine, aggregate control rate.

COMMON FAILURE MODES

- Improvement is assumed generally, without specific, measured targets.
- Results aren't documented, relying on general impression alone.
- No aggregate rate is calculated; only scattered individual data exists.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre with a diabetes registry (3.1) but no targets.

BEFORE

Clinicians reviewed HbA1c results and adjusted treatment by judgment. There was no defined target. When the Coordinator applied the national target of <7% to the registry, 34% of diabetics were at target; clinicians had estimated 'most.' Hypertension: 41% at <140/90.

ACTION

Targets were adopted from national guidance and individualised where appropriate (frail elderly, hypoglycaemia risk). Each patient's registry entry shows the target and the current value with a red/green flag. The practice-level proportion at target is reported monthly. Clinicians receive their own panel's proportion at target.

AFTER

The Monitor reviewed the registry with target flags, six monthly reports (diabetes at target 34% → 51%; hypertension 41% → 58%), and clinician-level feedback. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Adopt national control targets for diabetes and hypertension.
2. Apply them to your registry: what proportion is at target?
3. Show the target and current value on every registry entry.
4. Report the proportion at target monthly.

The most common mistake: Treating 'lower than last time' as success — the target is the target.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Control target measurement documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: Aggregate control rate documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.

- **Aggregate rates are calculated periodically but not reviewed often enough to drive real, timely improvement.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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

NON-NEGOTIABLE

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.

In plain terms: The practice runs its chronic disease list to find patients overdue for tests or visits — especially those who have not been seen at all — and contacts them.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

The registry (3.1) and targets (3.2) identify who is overdue. This criterion asks that the practice does something about it: a phone call, a letter, an outreach visit. The patients who are overdue are disproportionately the ones at highest risk — they have stopped coming because they feel fine, because they cannot afford it, because they are depressed, because they have moved. Proactive outreach finds the diabetic with an HbA1c of 12% who has not been seen in 18 months. Waiting for them to come back means waiting for the complication.

WHAT GOOD LOOKS LIKE

COMMON FAILURE MODES

- Overdue patients are genuinely, actively identified through a real process.
- Active outreach genuinely follows identification, not just passive awareness.
- Patients with poor control are specifically prioritized in outreach.

- The practice waits passively for overdue patients to schedule their own visit.
- Identification happens but doesn't lead to genuine outreach.
- Outreach, if it happens, doesn't prioritize the highest-risk patients.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre with a registry showing 180 diabetics overdue for HbA1c.

BEFORE	The overdue list existed. Nobody acted on it. Outreach was 'not something we do.' Of the 180, 60 had not attended in over a year. Two of those were later found to have developed diabetic foot ulcers requiring hospital admission.
ACTION	A monthly outreach process was established: the nurse phones every patient overdue for a key measure, books a visit, and records the outcome. Patients who cannot be reached by phone get a letter, then a home visit by a community health worker for the highest-risk. Outreach outcomes are tracked: contacted, booked, attended.
AFTER	The Monitor reviewed four months of outreach logs: 320 contacts, 210 attended; the number overdue for HbA1c fell from 180 to 55. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Run your registry for patients overdue for a key measure by more than six months.
2. Sort by last visit date — who has not been seen at all?
3. Phone them, starting with the longest absent.
4. Track contacted, booked, attended.

The most common mistake: Generating the overdue list and filing it — the list is the beginning of the work, not the end.

SELF-ASSESSMENT QUESTIONS

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.*
Evidence: Overdue patient identification process

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.*
Evidence: Outreach record

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.*
Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Outreach happens once but isn't repeated if the initial attempt doesn't succeed.**

IMPLEMENTATION PLAN

When	What
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.

When	What
Ongoing	Track outreach attempts and successful contact rates.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

3.4 Team-Based Care Coordinates Chronic Disease Management

CORE

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.

In plain terms: Nurses, pharmacists, and other team members share chronic disease management with the doctor — running reviews, adjusting within protocols, educating — not everything through the doctor alone.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

A doctor with 500 diabetic patients cannot see each one quarterly and do everything. A nurse can run the foot check, the education, the recall. A pharmacist can review medications and adjust doses within a protocol. A community health worker can do outreach. Team-based care is how primary care scales: the doctor does what only a doctor can do; the rest is shared. It requires defined roles, written protocols for what each team member may do, and communication — a shared record, a team huddle, a case review. A practice where the doctor does everything is a practice where a lot does not get done.

WHAT GOOD LOOKS LIKE

- Chronic disease management genuinely involves the full care team.
- Team members have clear, specific, defined roles.
- Real evidence shows team-based care is genuinely improving control rates.

COMMON FAILURE MODES

- Chronic disease management falls entirely on the physician alone.
- Team roles are ambiguous or overlapping, with no clear ownership.
- No evidence connects team involvement to genuine outcome improvement.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre with two doctors, three nurses, and no team-based chronic care.

BEFORE

All diabetic reviews were doctor appointments. Nurses did vital signs and vaccinations. The doctors were overwhelmed; 15-minute diabetes reviews covered medication only; foot and eye checks, education, and dietary review were rarely done. Waiting time for a diabetes review was eight weeks.

ACTION

A nurse-led diabetes clinic was created: nurses run a 30-minute structured review (HbA1c, BP, foot check, eye referral, education, medication adherence) under a written protocol, with doctor review for patients above target or with complications. A pharmacist reviews medications quarterly and adjusts within protocol. A weekly team huddle discusses complex patients. The doctor sees patients who need medical decisions.

AFTER

The Monitor observed a nurse-led review, reviewed the protocol and huddle records, and saw the diabetes review waiting time fall from eight weeks to two. Foot checks: 20% → 85%. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. List what a diabetes review should include. How much of it does the doctor actually do in 15 minutes?
2. Write a nurse-led review protocol.
3. Define what the pharmacist may adjust.
4. Start a weekly team huddle.

The most common mistake: Keeping every chronic disease decision with the doctor because 'the doctor is responsible' — responsibility can be structured, not hoarded.

SELF-ASSESSMENT QUESTIONS

1. Does chronic disease management genuinely involve the full care team, not the physician alone? — *Real, coordinated team involvement, not physician-only management.*

Evidence: Team-based care role documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: Team-based care outcome evidence

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Roles are defined but not consistently followed in actual daily practice.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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

NON-NEGOTIABLE

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.

In plain terms: When a patient's diabetes or blood pressure is not at target, treatment is adjusted according to a written stepped process at defined intervals — not left unchanged visit after visit.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Full	Full

WHY THIS MATTERS

Clinical inertia — seeing a patient above target and not changing treatment — is the most common failure in chronic disease management. The HbA1c is 8.5%, the visit is busy, the patient seems fine, the medication is left as it is. Six months later, the same. A defined process breaks inertia: if above target at review, adjust per the stepped protocol (increase dose, add agent, refer); recheck at a defined interval (three months for diabetes); document the decision or the reason for not adjusting. The protocol makes adjustment the default and inaction the exception that needs justifying.

WHAT GOOD LOOKS LIKE

- Treatment adjustment follows a specific, defined process when targets aren't met.
- Adjustment happens within a genuine, reasonable timeframe.
- Defined follow-up confirms whether an adjustment actually worked.

COMMON FAILURE MODES

- Treatment remains unchanged indefinitely despite a patient not meeting target.
- Adjustment, when it happens, is significantly delayed with no defined timeframe.
- No follow-up confirms whether an adjustment succeeded.

WORKED EXAMPLE

IN PRACTICE

A 4-room health centre with a diabetes registry showing many patients above target for years.

BEFORE	Patients above target were reviewed and their medication continued unchanged. The Coordinator found 40 patients with HbA1c above 8% for over two years with no treatment change. Clinicians said 'we discussed lifestyle' or 'they didn't want more medication' — undocumented.
ACTION	A stepped medication adjustment protocol was adopted from national guidance for diabetes and hypertension: at each review, if above target → adjust per protocol step; if not adjusted → document the reason (patient preference, hypoglycaemia risk, etc.); recheck at three months. The registry flags patients above target with no adjustment in six months for review at the team huddle.
AFTER	The Monitor reviewed 30 records of patients above target: all showed adjustment or a documented reason; the registry flag list had fallen from 40 to 8. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Run your registry: patients above target for over a year with no medication change.
2. Adopt a stepped protocol for diabetes and hypertension.
3. Require adjustment or a documented reason at every review.
4. Flag non-adjusted patients for team review.

The most common mistake: Continuing the same treatment because the patient 'seems fine' — the complications come later, quietly.

SELF-ASSESSMENT QUESTIONS

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.

Evidence: Treatment adjustment protocol documentation

2. Does adjustment happen within a reasonable, defined timeframe, not delayed indefinitely? — *A specific, genuine timeframe, not an open-ended delay.*

Evidence: Adjustment timing record

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.*

Evidence: Post-adjustment follow-up record

COMMON REASONS FOR A PARTIAL ANSWER

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

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
DOCUMENT	Adjustment protocol review	Reviews the specific, defined process for treatment adjustment when targets aren't met.

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Primary Health Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 2 — Preventive Care & Screening**

Standard 4 — Acute & Same-Day Care →

ASF STANDARDS · PRIMARY HEALTH CLINIC · STANDARD 4

Standard 4 — Acute & Same-Day Care

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

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

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

4.3 — Telephone or Remote Triage Follows a Structured, Validated Protocol

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

4.5 — A Dedicated, Ready Emergency Response Exists for a Deteriorating Patient

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

NON-NEGOTIABLE

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.

In plain terms: Reception and intake staff — not just the doctor — know the red flag symptoms that mean 'see this person now' and have a way to escalate immediately.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

The patient with crushing chest pain tells the receptionist, who books them for 3pm. The child with a non-blanching rash waits behind six coughs. The intake staff are the first contact and the first filter; if they do not know the red flags, the red flags wait. A short list — chest pain, breathing difficulty, severe headache with fever, non-blanching rash, sudden weakness, heavy bleeding, suicidal statements — with a rule ('tell a clinician immediately, do not book') and a demonstrated route, turns reception into a safety net. It takes 30 minutes to train and is refreshed annually.

WHAT GOOD LOOKS LIKE

- Intake staff are specifically, genuinely trained to recognise defined red flags.
- A specific, immediate escalation process exists and is followed.
- A dedicated space is genuinely ready for a patient identified with a potential emergency.

COMMON FAILURE MODES

- Red flag recognition is left entirely to the clinician, not intake staff.
- No specific, immediate escalation process exists beyond the normal queue.
- No dedicated space is genuinely ready when a red flag is identified.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre where reception booked patients by request.

BEFORE

Reception asked 'what is it about?' and offered the next slot. A patient with chest pain was booked for the afternoon and had a myocardial infarction in the waiting room. Reception staff had no red flag training and no clear way to interrupt a clinician.

ACTION

A ten-item red flag list was written for the practice's population, printed at reception and at the phone. The rule: any red flag → tell a clinician immediately by walking to the consulting room or using the intercom, do not book. All intake staff completed a 30-minute session with scenarios. A monthly scenario refresher was added. The escalation is logged.

AFTER

The Monitor reviewed the list, training records, and the escalation log (nine escalations in three months, all appropriate). Asked a receptionist what she would do for a patient reporting sudden facial drooping; she described immediate escalation. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask your receptionist what they would do if a patient said 'chest pain.'
2. Write a ten-item red flag list for your population.
3. Train all intake staff — 30 minutes with scenarios.
4. Define and test the escalation route.

The most common mistake: Assuming reception will 'use common sense' — common sense books the chest pain for 3pm because that is the next slot.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Intake staff red flag training record

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.*

Evidence: Red flag escalation protocol

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.

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **A ready space exists but is sometimes occupied, without a clear, defined alternative.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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

NON-NEGOTIABLE

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.

In plain terms: The practice measures whether patients who genuinely need to be seen today actually are — with a target — rather than assuming access is fine.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

'We always fit people in' is a belief. 'Last month, 78% of same-day requests were seen the same day' is a measurement. The gap between them is the patients who went to the emergency department,

or waited three days with a worsening infection, or gave up. Same-day access is the difference between primary care as a first resort and primary care as an obstacle. Measuring it — how many asked, how many were seen — reveals whether the appointment system works, whether there are enough slots, whether the triage is right. Then it can be fixed.

WHAT GOOD LOOKS LIKE

- Same-day access is genuinely, actively measured against real demand.
- A specific, defined target exists and is tracked.
- A genuine response follows when access falls short of target.

COMMON FAILURE MODES

- Same-day access adequacy is assumed without genuine measurement.
- No specific target exists; adequacy is judged by general impression.
- Shortfalls, if identified, produce no genuine response.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre that believed it offered good same-day access.

BEFORE

No measurement. Clinicians believed 'everyone urgent gets seen.' When the Coordinator logged same-day requests for two weeks: 140 requests, 82 seen same day (59%). The rest were booked for the next day or later; 12 went to the emergency department that evening.

ACTION

A same-day access measure was defined: proportion of patients requesting a same-day appointment for a genuine need (per triage) who are seen that day. Target 90%. Slots were restructured: 40% of daily capacity held for same-day, released at 8am. A duty clinician handles overflow. The measure is reported weekly.

AFTER

The Monitor reviewed 12 weeks of same-day access data: 59% → 91%. Reviewed the slot structure and the duty clinician rota. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. For two weeks, log every same-day request and whether it was met.
2. Calculate the proportion. Under 80% is a problem.
3. Restructure slots to hold capacity for same-day.
4. Report weekly.

The most common mistake: Believing access is good because clinicians are busy — busy and accessible are not the same.

SELF-ASSESSMENT QUESTIONS

1. Does the practice actively measure whether genuine same-day requests are actually accommodated that day? — *Real, calculated measurement, not an assumption of adequacy.*

Evidence: Same-day access measurement record

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.*

Evidence: Same-day access target documentation

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.*

Evidence: Access shortfall response record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.

- **Shortfalls are identified but the response addresses only the immediate day, not underlying causes.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

4.3 Telephone or Remote Triage Follows a Structured, Validated Protocol

NON-NEGOTIABLE

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.

In plain terms: When a patient phones with a same-day need, the triage decision follows a structured, validated protocol — not each nurse's or receptionist's personal judgment.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Telephone triage decides who is seen now, who is seen today, who is seen this week, and who is given advice. Done by unstructured judgment, it depends on who answers the phone, how busy they are, and how persuasive the caller is. Validated protocols — symptom-based algorithms with defined questions and defined outcomes — make triage consistent, safe, and auditable. They protect the patient from being under-triaged and the staff from being blamed for a decision the protocol would have supported. The protocol must be one the practice has adopted, trained on, and audits.

WHAT GOOD LOOKS LIKE

- Triage genuinely follows a structured, validated protocol.
- The protocol is consistently used across all staff conducting triage.

COMMON FAILURE MODES

- Triage depends on individual judgement, applied inconsistently.
- 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.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre where reception triaged by asking 'is it urgent?'

BEFORE

Reception decided who got a same-day slot based on the caller's answer. A child with a two-day fever and lethargy was booked for the next day; she had meningitis. A patient with a minor rash was seen the same day because he insisted. There was no protocol and no training.

ACTION

A validated telephone triage protocol was adopted (national nurse triage system). Clinical triage moved from reception to a trained nurse. Every call is triaged with the protocol's structured questions, recorded, and given a defined outcome: emergency, same day, this week, advice. Reception takes messages and routes clinical calls to the triage nurse. A monthly audit of 20 calls checks protocol adherence and outcomes.

AFTER

The Monitor reviewed the protocol, the nurse training records, and 20 audited calls with protocol-consistent outcomes. Listened to a recorded triage call. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Who triages phone calls in your practice? With what protocol?
2. Adopt a validated telephone triage system.
3. Train a nurse and route clinical calls to them.
4. Audit 20 calls a month.

The most common mistake: Letting the caller's insistence determine urgency — the sickest patients are often the least insistent.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Triage protocol documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Red flag prompting happens but isn't consistently documented, making genuine adherence hard to verify.**

IMPLEMENTATION PLAN

When	What
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.

When	What
Ongoing	Audit triage documentation for genuine, consistent protocol adherence.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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

NON-NEGOTIABLE

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.

In plain terms: When symptoms could be something serious or something ordinary, the clinician actively considers the serious option and documents why it was ruled out — not defaults to the benign diagnosis.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Full	Full

WHY THIS MATTERS

Most chest pain in primary care is musculoskeletal. Most headaches are tension. Most abdominal pain is benign. The clinician sees a hundred benign cases for every serious one, and the mind adapts: this is probably nothing. That adaptation is how the aortic dissection is sent home with antacids and the subarachnoid haemorrhage is treated as migraine. Diagnostic safety means the clinician consciously asks 'what serious condition could this be?' and documents the answer — the red flags asked about, the examination done, the reason the serious option was excluded. The documentation is the discipline.

WHAT GOOD LOOKS LIKE

- Serious alternative diagnoses are genuinely, actively considered for atypical presentations.
- Diagnostic reasoning, including ruled-out alternatives, is genuinely documented.
- A defined safety-net process exists for uncertain presentations.

COMMON FAILURE MODES

- Overlap with a common, benign condition is treated as sufficient to rule out something more serious.
- Diagnostic reasoning isn't documented beyond the final diagnosis reached.
- No defined safety-net exists for a patient whose presentation remains uncertain.

WORKED EXAMPLE

IN PRACTICE

A 4-room health centre with a diagnostic delay incident.

BEFORE	A 55-year-old man with 'indigestion' was given antacids on two visits; the third visit was to the emergency department with a myocardial infarction. The consultation notes recorded 'epigastric pain — likely dyspepsia — antacids.' No cardiac risk assessment, no ECG, no documented consideration of cardiac cause.
ACTION	The practice adopted a 'serious alternative' discipline: for defined presentations (chest pain, headache, abdominal pain, back pain, fatigue, weight loss), the consultation template includes a 'serious causes considered' field requiring the clinician to name the serious alternative and document what excluded it. A monthly case review discusses one diagnostic challenge. Clinicians completed a half-day on diagnostic error.
AFTER	The Monitor reviewed 30 consultation records for the defined presentations: all documented serious alternatives and exclusion reasoning. Reviewed three monthly case review records. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull ten chest pain and ten headache consultations. Does the note say what serious cause was considered?
2. Add a 'serious causes considered' field to templates for high-risk presentations.
3. Start a monthly diagnostic case review.
4. Train on diagnostic error.

The most common mistake: Diagnosing the common thing because it is common — the note should show the serious thing was actively ruled out.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: N/A — tested directly

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.*

Evidence: Diagnostic reasoning documentation

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.*

Evidence: Safety-net advice protocol

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Reasoning is documented for complex cases but less consistently for presentations that seem straightforward.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy →](#)

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

4.5 A Dedicated, Ready Emergency Response Exists for a Deteriorating Patient

CORE

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.

In plain terms: The practice has a defined process and a physical space for a patient who collapses or arrives in crisis — with the equipment there, staff who know their roles, and a rehearsed plan.

Facility category	Crisis	Transition	Small	Standard
Applicability	Full	Full	Adapted	Full

WHY THIS MATTERS

Primary care is not designed for emergencies, but emergencies come anyway: the anaphylaxis after a vaccine, the cardiac arrest in the waiting room, the child with a seizure. The practice needs a space (a treatment room that can be cleared in seconds), equipment (oxygen, adrenaline, airway kit, AED), a process (who does what, who calls the ambulance, where the patient goes), and rehearsal (a drill twice a year). A practice that improvises will lose minutes it does not have.

WHAT GOOD LOOKS LIKE

- A specific, dedicated space and process are genuinely ready for a deteriorating patient.
- Emergency equipment is genuinely checked and verified as functional.
- Staff roles are specifically defined and confidently known.

COMMON FAILURE MODES

- No specific process exists beyond an assumption staff would respond appropriately.
- Emergency equipment condition is assumed, not verified.
- Staff are uncertain about their specific role during a genuine emergency.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre with emergency equipment in a locked cupboard and no designated space.

BEFORE

When a patient collapsed in the corridor, staff moved him to the floor of a consulting room with a patient in it, searched for the emergency kit

(locked; key with the practice manager who was out), and called an ambulance from reception. Eleven minutes passed before oxygen was applied.

ACTION

The largest treatment room was designated as the emergency space, kept clear of stored items, with the emergency kit on an open shelf. Roles were written: clinician leads, nurse manages airway and drugs, receptionist calls ambulance and clears the way, another staff member manages other patients. A drill is run twice a year and debriefed. The kit is checked daily (linking to the ambulatory 5.2 equivalent).

AFTER

The Monitor found the designated room clear with the kit accessible, reviewed the role card and two drill records, and asked three staff their roles; all answered. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Where is your emergency kit? Is it locked? Who has the key?
2. Designate one room as the emergency space and keep it clear.
3. Write a role card: who leads, who calls, who clears.
4. Run a drill this month.

The most common mistake: Locking the emergency kit to prevent theft — the emergency happens when the key-holder is out.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Emergency response protocol documentation

2. Is emergency equipment genuinely checked and ready, not assumed functional without verification? — *Real, verified readiness, not assumed equipment condition.*

Evidence: Equipment check record

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **Equipment is present but checking happens irregularly, without a defined schedule.** — A defined, regular check schedule is what makes equipment readiness genuinely reliable.
- **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.
- **The pathway to emergency services is known by senior staff but not consistently by newer team members.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Primary Health Clinic Standards — all standards**

Self-assess against these criteria →

← **Standard 3 — Chronic Disease Management**

Standard 5 — Referral & Care Coordination →

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ASF STANDARDS · PRIMARY HEALTH CLINIC · STANDARD 5

Standard 5 — Referral & Care Coordination

5 criteria · 4 non-negotiable · 1 core · Version 3.0

CRITERIA IN THIS STANDARD

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

5.2 — Specialist Findings Return to the Referring Clinician Within a Defined Timeframe

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

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

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

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

NON-NEGOTIABLE

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.

In plain terms: Every referral to a specialist is tracked until the appointment has actually happened — not assumed to have happened because the letter was sent.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

This is the PHC version of ambulatory 4.8, and in primary care the volume is higher and the consequences equally grave. The referral for the breast lump, the suspicious mole, the rectal bleeding — if it does not arrive, or the patient does not go, or the specialist does not see them, the cancer grows in the gap. Tracking means a log from referral sent to appointment confirmed to patient attended, checked at intervals, with a chase for anything not confirmed. A practice that sends referrals and forgets them has an unknown number of patients in limbo.

WHAT GOOD LOOKS LIKE

- Every referral is genuinely tracked through to documented completion.
- A specific process identifies referrals that haven't completed within an expected timeframe.
- Genuine follow-up action resolves identified gaps, not just notes them.

COMMON FAILURE MODES

- Referrals are assumed complete once sent, with no active tracking.
- No process identifies referrals that have stalled or failed to complete.
- Incomplete referrals are recognized but not actively resolved.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre sending 150 referrals a month.

BEFORE

Referrals were sent by letter or electronic system. No log. The Coordinator sampled 40 referrals from three months earlier: 13 had no record of an appointment at the receiving facility; 4 were urgent (two suspected cancers). The practice had not known.

ACTION

A referral log was built in the EHR: every referral entered with urgency and expected appointment timeframe; the practice nurse reviews it weekly; any referral without appointment confirmation by the expected date is chased with the receiving facility and the patient; outcomes recorded. Urgent referrals are confirmed by phone within 7 days.

AFTER

The Monitor reviewed four months of the log: 600 referrals, 96% confirmed attended; 18 recovered by chasing. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Sample 30 referrals from three months ago. Phone the receiving facility: was the patient seen?
2. Build a referral log with expected dates.
3. Review weekly and chase anything unconfirmed.
4. Phone-confirm urgent referrals within 7 days.

The most common mistake: Treating the referral as complete when the letter leaves the building.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Referral tracking record

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.*

Evidence: Incomplete referral identification process

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.*

Evidence: Follow-up action record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Follow-up happens once but isn't repeated if the initial attempt doesn't resolve the gap.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

5.2 Specialist Findings Return to the Referring Clinician Within a Defined Timeframe

NON-NEGOTIABLE

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.

In plain terms: The specialist's findings come back to the referring doctor within a set time — and the practice chases them if they do not.

Facility category	Crisis	Transition	Small	Standard
Applicability	Adapted	Full	Adapted	Full

WHY THIS MATTERS

The patient saw the cardiologist. What did the cardiologist find? What did they change? Is the patient on a new medication that interacts with the one the GP prescribed? If the specialist letter does not arrive, or arrives three months later, the referring doctor manages the patient blind. A defined timeframe — two weeks for routine, 48 hours for urgent — with a chase for anything overdue, closes the loop. The

referral log (5.1) can track this: appointment confirmed → letter received → letter reviewed. A practice that does not track return of findings does not know what its specialists have done to its patients.

WHAT GOOD LOOKS LIKE

- A specific, defined timeframe governs when specialist findings should return.
- Receipt is actively confirmed, not assumed.
- A real follow-up process addresses findings that don't arrive as expected.

COMMON FAILURE MODES

- No specific timeframe exists; findings arrive whenever they happen to.
- Receipt is assumed unless a problem becomes obvious.
- No follow-up occurs when expected findings don't arrive.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre with referrals tracked to appointment (5.1) but not to findings.

BEFORE

Specialist letters arrived by post when they arrived. The Coordinator found 30 patients whose specialist appointments had been confirmed but whose letters had not been received two months later. In three cases, medications had been changed by the specialist without the practice knowing.

ACTION

The referral log was extended: after appointment confirmation, a 'findings received' date with an expected timeframe (14 days routine, 2 days urgent). The nurse chases any overdue letter with the receiving facility. Received letters are flagged for the referring clinician's review within 48 hours and medication changes are reconciled.

AFTER

The Monitor reviewed three months of the extended log: 92% of findings received within timeframe; 25 chased and obtained; all reviewed with medication reconciliation where relevant. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. From your referral log, list confirmed appointments with no specialist letter received.
2. Set a timeframe: 14 days routine, 2 days urgent.
3. Chase every overdue letter.
4. Reconcile medications from every specialist letter.

The most common mistake: Assuming the specialist will write — many do, eventually; the ones who do not leave the patient's GP in the dark.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Specialist return timeframe documentation

2. Is receipt of specialist findings actively confirmed, not assumed if nothing seems to go wrong? — *Genuine, active confirmation, not passive assumption of receipt.*

Evidence: Receipt confirmation record

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.*

Evidence: Missing findings follow-up process

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Follow-up happens for referrals the clinician specifically remembers but not systematically across all pending referrals.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

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

NON-NEGOTIABLE

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.

In plain terms: At every step of a referral — sending, confirming, receiving findings, follow-up — one named person or role is responsible, so nothing is 'someone else's job.'

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

Referrals fail in the gaps between people: the doctor sent it, the receptionist filed it, the nurse assumed the doctor would chase it, the doctor assumed the receptionist would. Explicit assignment — 'the referral coordinator confirms appointments; the referring clinician reviews findings; the practice nurse chases overdue items' — closes the gaps. It is written in the referral process, known by everyone, and visible in the log. When something goes wrong, the question 'whose job was it?' has an answer.

WHAT GOOD LOOKS LIKE

- Specific, explicit responsibility is assigned at every referral stage.
- Staff can confidently, consistently identify who owns each stage.
- Assignment is genuinely kept current as staff and

COMMON FAILURE MODES

- Responsibility is shared or assumed, with no specific ownership.
- Staff give inconsistent or uncertain answers about who is responsible.
- Assignment structure is outdated, not reflecting

roles change.

who actually does the work.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre with a referral process everyone thought someone else owned.

BEFORE

When a referral was lost, the doctor said reception should have sent it; reception said the doctor should have checked; the nurse said it was not her role. The process had steps but no owners. Referrals fell between them regularly.

ACTION

The referral process was documented with a named role at every step: referring clinician (creates and reviews findings), referral coordinator (sends, confirms appointment, chases), practice nurse (reviews overdue log weekly, contacts patients), practice manager (monthly audit). The roles are printed on the process sheet and in the log headers.

AFTER

The Monitor reviewed the process document with named roles, the log showing each step's owner, and interviewed the referral coordinator who described her responsibilities precisely. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask three staff who is responsible for chasing an unconfirmed referral. If the answers differ, that is the gap.
2. Write the referral process with one named role per step.
3. Print it and put it where the work happens.
4. Add the owner to each column of the log.

The most common mistake: Shared responsibility — when everyone is responsible, no one is.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Referral process role assignment documentation

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.*

Evidence: N/A — tested directly

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.*

Evidence: N/A — tested directly

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Assignment was accurate at one point but hasn't been updated following recent staff changes.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

[ASF training courses on GMJ Academy](#) →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

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

NON-NEGOTIABLE

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.

In plain terms: An urgent referral — suspected cancer, a serious finding — is tracked and chased faster and harder than a routine one, with shorter clocks and phone confirmation.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Full	Full

WHY THIS MATTERS

A referral for a suspected melanoma and a referral for a routine hernia repair should not sit in the same queue with the same follow-up. The urgent one has a two-week clock (or whatever the national standard is); it must be confirmed received, confirmed booked, confirmed attended — by phone, not by waiting for a letter. If it is not booked within the standard, it is escalated. The routine referral can wait for the monthly check. A practice that treats all referrals the same is treating the urgent ones too slowly.

WHAT GOOD LOOKS LIKE

- Urgent referrals genuinely receive more intensive tracking than routine ones.
- Urgency is explicitly, clearly communicated to the receiving specialist.
- A genuinely shorter timeframe governs identification of incomplete urgent referrals.

COMMON FAILURE MODES

- Every referral is tracked identically, regardless of clinical urgency.
- Urgency is left for the specialist to infer, not explicitly communicated.
- The same timeframe applies to urgent and routine referrals alike.

WORKED EXAMPLE

IN PRACTICE

A 5-room health centre with a single referral log and monthly review.

BEFORE

All referrals were reviewed monthly. An urgent suspected cancer referral was sent, not confirmed, and picked up at the monthly review

	five weeks later — the patient had not been seen. Urgency was noted on the referral but did not change the tracking.
ACTION	The referral log was split by urgency. Urgent referrals: phone confirmation of receipt within 2 working days, appointment confirmed within 7 days, attended confirmed within 14 days; any breach escalated to the referring clinician and the receiving facility's referral lead the same day. Routine referrals: monthly review. The nurse checks the urgent list daily.
AFTER	The Monitor reviewed three months of urgent referrals: 45 sent, all confirmed within 2 days, 43 seen within 14 days, 2 escalated and resolved. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Pull your last ten urgent referrals: how long from sending to confirmed appointment?
2. Split the log by urgency.
3. Set short clocks for urgent: 2 days, 7 days, 14 days.
4. Check the urgent list daily.

The most common mistake: Marking a referral 'urgent' and tracking it on the same monthly cycle as everything else.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Urgency-differentiated tracking documentation

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.*

Evidence: N/A — tested directly

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.

Evidence: Urgent referral timeframe documentation

COMMON REASONS FOR A PARTIAL ANSWER

- **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.
- **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.
- **Urgency differentiation is clear for obviously urgent cases but less consistent for moderately time-sensitive ones.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

5.5

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

CORE

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.

In plain terms: The patient is actively helped through the referral — told what to expect, helped to book, reminded, checked on afterward — not handed a letter and left to manage it alone.

Facility category	Crisis	Transition	Small	Standard
Applicability	N/A	Full	Adapted	Full

WHY THIS MATTERS

'Here is a referral letter, the hospital will contact you' is the start of a process the patient does not understand. Which hospital? When? What happens there? What if they do not call? Patients who are anxious, elderly, non-native speakers, or in unstable circumstances are the least able to navigate — and the most likely to need the referral. Support means: a plain-language explanation of what the referral is for and what will happen; help booking where the patient must book; a reminder before the appointment; a check afterward. The referral coordinator (5.3) can do this; it is what makes the referral real for the patient.

WHAT GOOD LOOKS LIKE

- Patients receive genuine, active support through the referral process.
- A specific, known contact exists for patient questions or difficulties.
- Genuine follow-up occurs when initial contact doesn't result in scheduling.

COMMON FAILURE MODES

- Patients are handed a referral and left entirely responsible for the rest.
- No specific contact exists for patient questions during the process.
- The process ends after one contact attempt, regardless of whether scheduling occurred.

WORKED EXAMPLE

IN PRACTICE

A 6-room health centre serving an elderly and multilingual population.

BEFORE

Referral letters were handed over with 'they'll contact you.' Non-attendance at specialist appointments was 30%. Interviewed patients said they did not know what the referral was for, had not understood the appointment letter, or had no transport.

ACTION

The referral coordinator now explains every referral in plain language (or via interpreter), gives a printed sheet ('You are being referred to X for Y; they will contact you by Z; if not, call us'), books the appointment with the patient where self-booking is required, sends a reminder two

days before, and phones after to check attendance and understanding. Transport assistance is arranged for those who need it.

AFTER

The Monitor reviewed 30 referrals with documented explanation, reminders, and post-attendance check. Non-attendance fell from 30% to 11%. Interviewed a patient who described the support. Verified.

IF YOU ARE STARTING FROM ZERO — DO THIS FIRST

1. Ask five recently referred patients what they were referred for and what happens next.
2. Create a plain-language referral sheet.
3. Send a reminder two days before every specialist appointment.
4. Phone afterward to confirm attendance and understanding.

The most common mistake: Assuming the patient can navigate the health system as well as you can.

SELF-ASSESSMENT QUESTIONS

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.*

Evidence: Patient referral support documentation

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.*

Evidence: Patient support contact information

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.*

Evidence: Patient follow-up record

COMMON REASONS FOR A PARTIAL ANSWER

- **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.

- **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.
- **Follow-up happens once after a failed contact attempt but isn't repeated if that follow-up also doesn't succeed.**

IMPLEMENTATION PLAN

When	What
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.

HOW THE MONITOR VERIFIES THIS

Method	What	Detail
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.

SUPERVISOR TIPS

- **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.

EVIDENCE BASE

[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.

ASF training courses on GMJ Academy →

Foundation courses A-00 to A-03 are live. Criterion-specific modules are being developed and will link here when published.

← **Primary Health Clinic
Standards — all standards**

**Self-assess against these
criteria →**

← **Standard 4 — Acute &
Same-Day Care**

**Standard 6 — Clinical
Environment & Safety →**

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