phn
DARLING DOWNS
AND WEST MORETON

An Australian Government Initiative

Quality Improvement Toolkit for General Practice

Children and Young People in Care

July 2021

INTRODUCTION

The Quality Improvement Toolkit

This Quality Improvement (QI) Toolkit is made up of modules that are designed to support your practice to make easy, measurable, and sustainable improvements to provide best practice care for your patients. The Toolkit will help your practice complete QI activities using the Model for Improvement.

Throughout the modules you will be guided to explore your data to understand more about your patient population and the pathways of care being provided in your practice. Reflections from the module activities and the related data will inform improvement ideas for you to action using the Model for Improvement.

The Model for Improvement uses the Plan-Do-Study-Act (PDSA) cycle, a tried and tested approach to achieving successful change. It offers the following benefits:

- it is a simple approach that anyone can apply
- it reduces risk by starting small
- it can be used to help plan, develop, and implement change that is highly effective.

The Model for Improvement helps you break down your change into manageable pieces, which are then tested to ensure that the change results in measurable improvements, and that minimal effort is wasted.

There is an example using the Model for Improvement and a blank template for you to complete at the end of this module.

If you would like additional support in relation to QI in your practice, please contact Darling Downs and West Moreton PHN on practicesupport@ddwmphn.com.au

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Darling Downs and West Moreton PHN if you have any feedback regarding the content of this document.

CONTENTS

CHILDREN & YOUNG PEOPLE IN CARE

Children and young people in care describes the care of children and young people aged <18 years, who are unable to live with their family (usually due to abuse or neglect) and are placed with carers on a short-term or long-term basis.

Heath statistics for children in care including key health issues

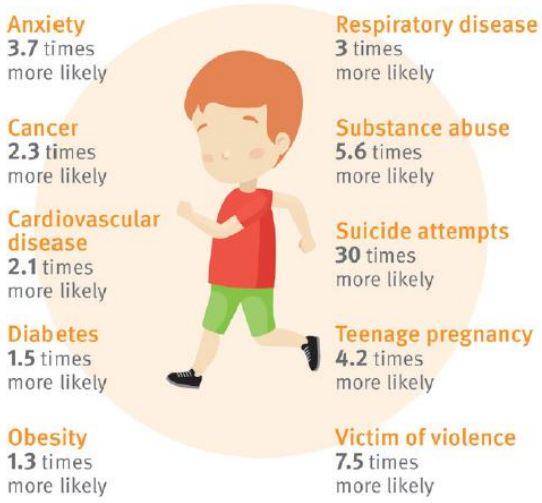
According to the Australian Institute of Welfare, during 2018–19:

- 170,200 (30 per 1,000) Australian children received child protection services (investigation, care, and protection order and/or were in care)
- Aboriginal and Torres Strait Islander children were 8 times as likely as non-Indigenous children to have received child protection services
- Children from geographically remote areas were more likely to be the subject of a substantiation, or be in care than those from major cities
- Over 3,700 children were reunified with family during 2018–19.[1]

Children in statutory care are known to have poorer physical, developmental, and mental health outcomes compared with their peers. The number of children in care is increasing in Australia, with Aboriginal and Torres Strait Islander children being disproportionately represented.[2]

Primary medical issues
• 14% have abnormal growth • 24% have incomplete vaccinations • 20% have abnormal vision screening • 28% have an abnormal hearing test • 30% have dental problems.
Trauma-related issues
• 54% have emotional or behavioural problems • Up to 63% have an eating disorder or obesity • 77% aged ≥ 12 years smoke every day • 45% aged < 5 years have a speech delay.[3]

The likelihood of health risks with four or more ACEs[3]



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[1] https://www.aihw.gov.au/reports-data/health-welfare-services/child-protection/reports
[2] https://pubmed.ncbi.nlm.nih.gov/31517415/
[3] Young People in Out-of-Home Care, Health Pathways Melbourne (2018)
[4] https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/dream-big/Dream-Big-Act-Big-for-Kids-Issue-1-ACEs-Toxic-Stress.pdf

Aboriginal and Torres Strait Islander children in care

Aboriginal and Torres Strait Islander children:

- have higher representation in care and youth justice compared to non-Indigenous peers
- are twice as likely to be developmentally vulnerable
- have higher incidence of hearing issues and diabetes
- have higher rate of mental health issues, in particular complex trauma
- require extra immunisations.

The NACCHO RACGP National Guide to a Preventive Health Assessment for Aboriginal and Torres Strait Islander People is a practical resource intended for all health professionals. It includes sections on children and young people with easy to use charts indicating the recommended screening by age.

Type of out of home care

There are different types of out of home care including:

- home-based care: kinship care, foster care
- family group homes
- residential care
- independent living
- other placements including boarding schools, hospitals, hotels or motels, and the defence force.

Health needs of children and young people in care

GPs are crucial in the early detection of health problems and intervention for this vulnerable population. Marked social and relational problems make the high-priority task of creating a safe and trusting environment a challenge. GPs must also work within statutory requirements and navigate the complex care system. Using recommended frameworks and maintaining effective communication and support will improve outcomes for these young people, their families, and the community. [5]

Young people in care are at an increased risk of the following health needs:

- **Emotional** (trauma, emotional dysregulation, attachment disorders, anxiety, mood disorders, deliberate self-harm, suicidality, risk taking behaviour, risk of harm- harm in care, exploitation by others- sexually, crime)
- **Developmental** (developmental delay - fine motor, gross motor, speech and language, social, inattention, hyperactivity, sensory seeking, sensory avoiding)

[5] https://www.racgp.org.au/afp/2016/october/meeting-the-primary-care-needs-%E2%80%A8of-young-people-in-residential-care/

- **Physical** (incomplete vaccinations, undiagnosed hearing or visual issues, acute medical conditions – illness, injury, chronic medical conditions, dental issues, nutrition issues, growth issues, sleep issues, sexually transmitted infections, smoking, alcohol, other substance use, teenage pregnancy)
- **School issues** (disengaged from school, school non-attendance, behavioural issues, behind academically, social issues, being bullied, bullying other kids).

Legal considerations on medical decision making

Section 97 of the *Child Protection Act* 1999 provides the authority for a health professional to medically examine a child subject to an order granting custody or guardianship to the chief executive. This provision may be exercised despite parents retaining guardianship of the child.

The Department of Child Safety, Youth and Women provides a guide for health professionals on medical decision-making for children and young people in out of home care.

Guide for health professionals

Medical decision making for children and young people in out-of-home care

What does the child or young person need?	Who is to provide consent when Child Safety has custody and parents retain guardianship?	Who within Child Safety can provide consent when Child Safety has guardianship?
Day to day/routine health care	The child or young person's carer Parents	The child or young person's carer Child Safety Senior Team Leader Child Safety Manager Child Safety After Hours Service Senior Team Leader or Manager
Prescribed medications to manage behaviour or mental health conditions	Parents	Child Safety Manager Child Safety After Hours Service Senior Team Leader or Manager
Immunisation	Child Safety Senior Team Leader Child Safety Manager	The child or young person's carer Child Safety Senior Team Leader Child Safety Manager Child Safety After Hours Service Senior Team Leader or Manager Regional Director – Child Safety
Blood tests (excluding DNA testing)	Parents	The child or young person's carer Child Safety Senior Team Leader Child Safety Manager Child Safety After Hours Service Senior Team Leader or Manager Regional Director – Child Safety
Dental — routine check-ups and treatment, not requiring a general anaesthetic	The child or young person's carer	The child or young person's carer Child Safety Senior Team Leader Child Safety Manager
Dental treatment, requiring a general anaesthetic	Parents	Child Safety Manager Child Safety After Hours Service Senior Team Leader or Manager Regional Director – Child Safety
Invasive medical and surgical procedures or considerations	Parents	Child Safety Manager Child Safety After Hours Service Senior Team Leader or Manager Regional Director – Child Safety
Acting on a second medical opinion	Parents	Depending on the type of illness/condition and proposed treatment: - Child Safety Manager - Child Safety After Hours Service Senior Team Leader or Manager - Regional Director – Child Safety
Other decisions relating to medical matters requiring a guardian's explicit consent	Parents	Child Safety Manager Child Safety After Hours Service Senior Team Leader or Manager Regional Director – Child Safety
Pregnancy termination	Parents	Regional Director – Child Safety
Contraception – when a child is under 12 years of age or a child is not considered "Gillick competent"	Parents	Regional Director – Child Safety
DNA testing	Parents	Regional Executive Director
End of life decisions	Parents	Director-General

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[6] https://www.csyw.qld.gov.au/resources/dcsyw/child-family/protecting-children/guide-for-health-professionals.pdf

Key goals and objectives of children and young people in care QI toolkit

This toolkit is to be used in general practice to:

- Improve the identification and recording of children and young people in care, including carer and child safety centres
- Ensure systems are in place at your practice to manage children and young people in care including always booking a longer appointment, uploading important information to My Health Record, and ensuring continuity of care is maintained (reminders, recalls)
- Outline the assessment and planning process and how to access relevant templates
- Identify Medicare Benefit Schedule (MBS) item numbers available for children and young people in care.

ACTIVITY 1 – CHILDREN & YOUNG PEOPLE IN CARE AND YOUR PRACTICE

GPs play a crucial role in the health care and wellbeing of children, young people and their families. Australia has a well-accepted system of health services based on the principles of primary health care to meet the needs of patients at multiple contact points.[7]

Being able to identify children and young people in your practice who are in care will assist with ongoing management of these patients.

New patient registration forms

To meet the RACGP Accreditation Standards, and obtain comprehensive patient information, practices should have a new patient registration form. Whilst it is not a requirement to include a question about living arrangements, your practice may consider including a tick box if the patient is currently in care, and obtain child safety service names and contact details.

To meet the requirements of information required for Smart Referrals, you will also need to know the following:

- If there are any custody or guardianship issues
- If the child is in out of home (foster) care
- The name of the child safety service centre.

Recording children in care status in patient's records

It is important for GPs and practices to easily identify patients who are currently in care. This is due to:

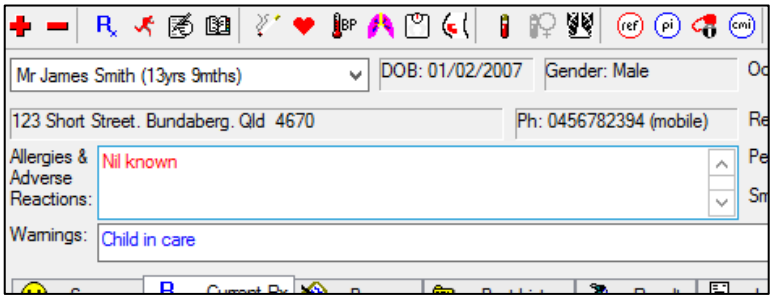
- **Risk factors** – children in care have substantially poorer health outcomes than their peers.
- **Legal reasons** – health professionals need to determine who has the authority to provide consent for the health and medical treatment of children and young people subject to child protection orders and placed in out of home care. Without knowing the child is in care, there are legal implications if the correct consent is not obtained. Despite the type of order, information can be shared that's in the best interest of the child with the carer, child safety, parent and other health professionals.
- **Identification** – kinship carers in particular may not articulate that the child is on a child protection order without being prompted and GPs may not ask if they assume the child is their own.
- **Referral to health services** - children in care may have dedicated priority access services (e.g., mental health) that they can be referred to at the hospital and in the community.

[7] https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/provision-of-healthcare-to-children-and-young

Recording information in MedicalDirector

To record child in care in Warnings:

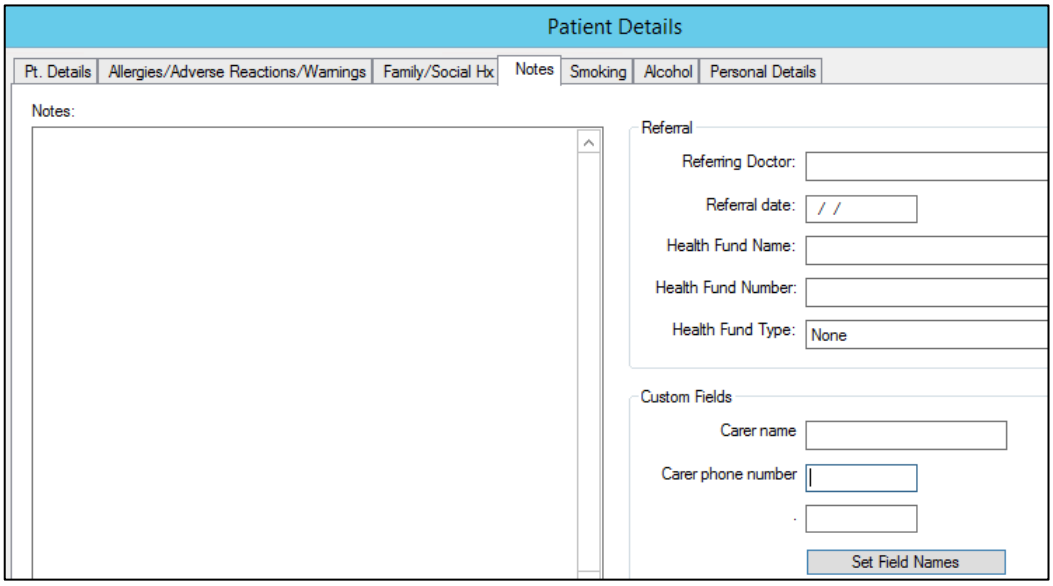
1. Open patient's file.
2. Double click on the white box next to **Warnings**.
3. Type **Child in care**.
4. Select **save**.



To record carer details:

If your practice does not currently use the custom fields in the patient details screen, you can edit these to include carer details. To do this:

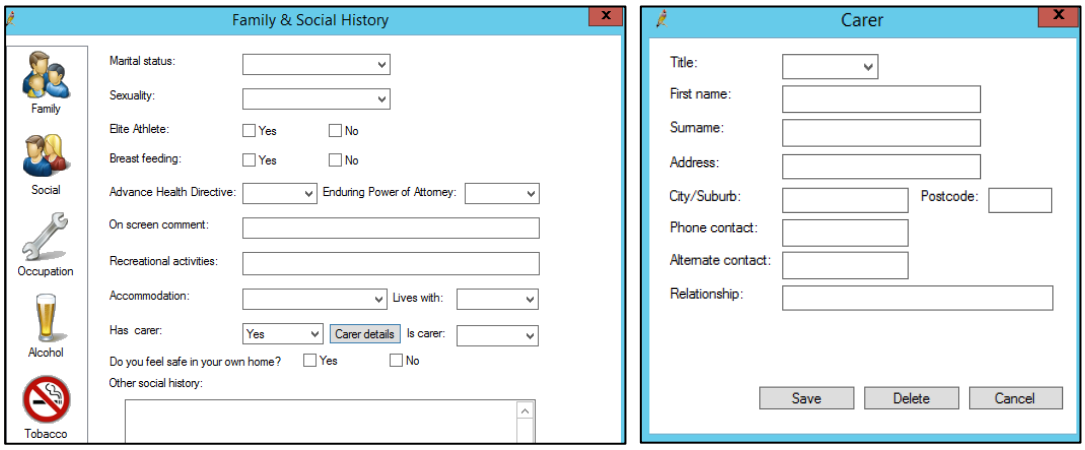
1. Open patient's file.
2. Open the **patient details** screen.
3. Select **notes**.
4. Under the **Custom Fields**, click on **Set Field Names**.
5. You are then able to customise 3 fields to suit the needs of your practice. In the example below, we have included **Carer name** & **Carer phone number**.
6. Click **Save** to close.



Recording information in Best Practice

To record child in care and carer details:

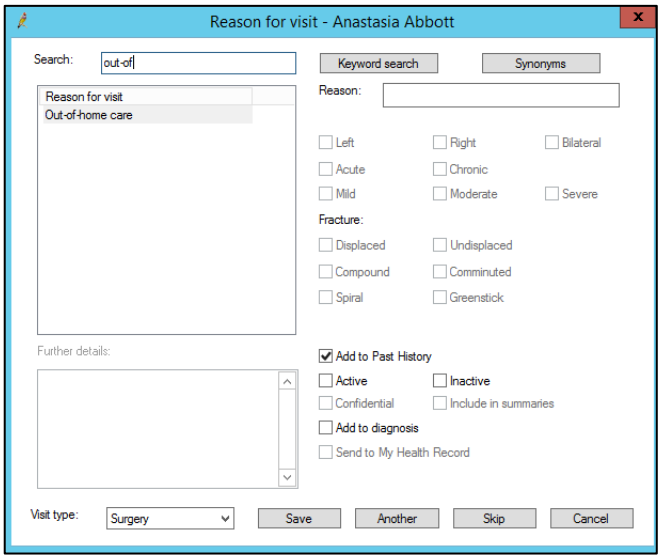
1. Open patient's file.
2. Open the family & social history screen.
3. Next to **On screen comment:** type Child in Care.
4. To enter carer details, select **yes** to has carer.
5. Click on the **Carer details** button.
6. Enter carer details and select **Save**.



Entering diagnosis &/or reason for visit in Best Practice

Best Practice users are able to enter in the diagnosis and reason for visit fields, **Out-of-home care.** To do this:

1. Open patient's file.
2. Under progress notes, select **Reason**.
3. In the search field, type **out-of-home care**.
4. You can choose to add this to **Past History**, include if it is **Active** or **Inactive**.
5. Click **Save** to record.



Activity 1.1 – Data collection from Best Practice

The aim of this activity is to collect data to determine the number of patients from your practice with a condition marked as out-of-home care. (Best Practice users only).

Instructions are available from Best Practice to search for this activity.

	Details	Total number
1.1a	Number of patients from your practice with a condition marked as out-of-home care	

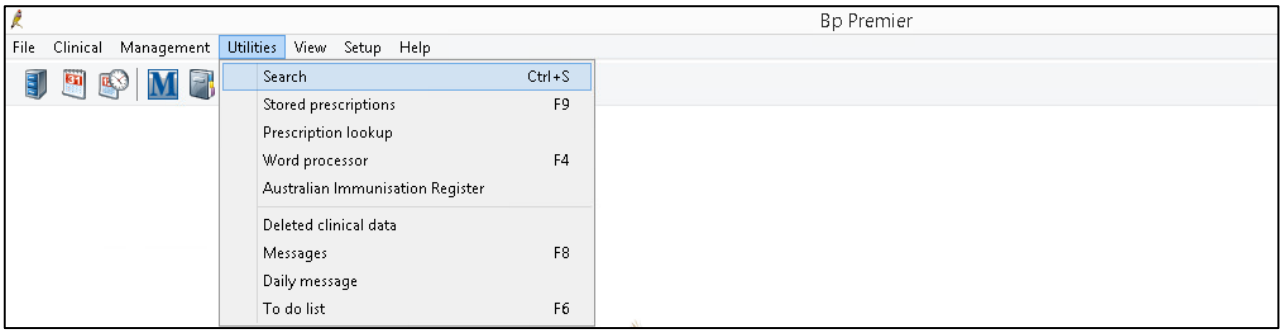
Reflection on **Activity 1.1:**

Practice name:	**Date:**
Team member:	

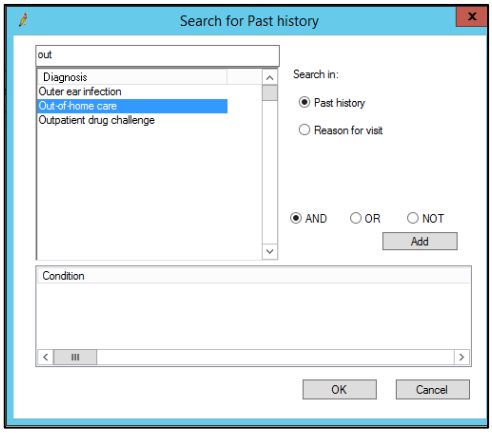
Instructions for searching the patient database in Best Practice

To conduct a search of patients with a condition marked in their past history in Best Practice:

1. From the Best Practice screen, select **Utilities** & **Search.**



2. From the **Setup search** menu, select **Conditions.**
3. A search for past history screen will appear.
4. In the **Diagnosis** box, enter the diagnosis you want to search for and select **Past history** or **Reason for visit.**
5. Select **Add.**
6. Select **OK.**
7. Select **Run Query** and your list of patients with the specific diagnosis will appear.

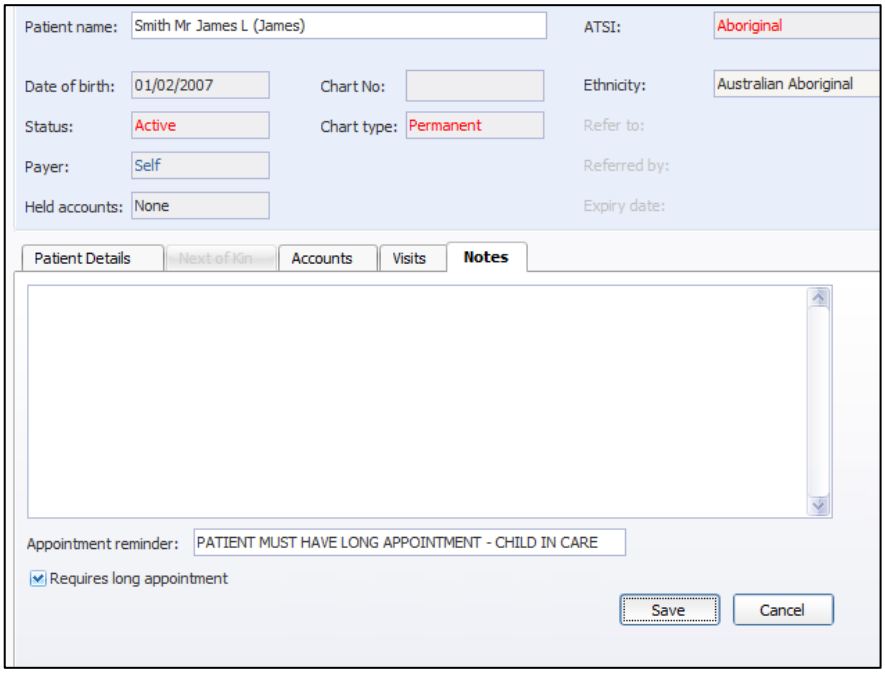


Setting appointment reminders to ensure long appointments are made for children and young people in care.

Children and young people in care are known to have poorer physical, developmental, and mental health outcomes compared with their peers, it is recommended to book a long appointment every time they present at the practice. You can set appointment reminders in your practice software to prompt the team member at the time of booking the appointment to allow more time.

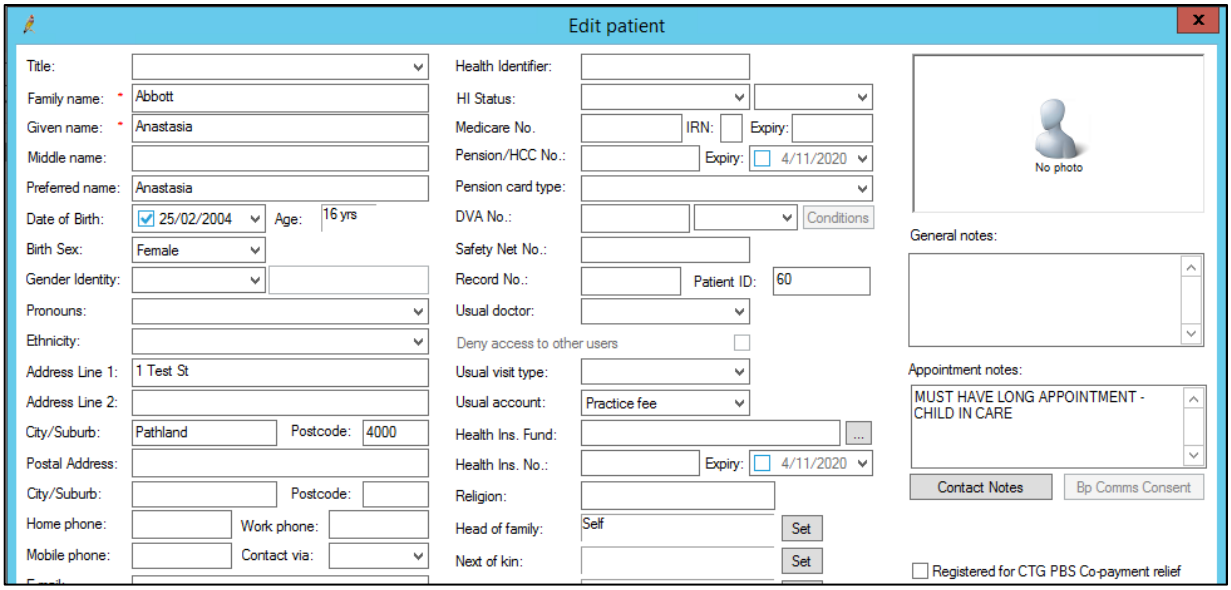
Instructions on setting up appointment reminder in Pracsoft.

1. Open the patient file.
2. Select **Notes**.
3. Type reminder in the **Appointment reminder** section.
4. Select **Requires long appointment.**
5. **Save** to complete.
6. Every time this patient is being booked in an appointment; these prompts will appear.

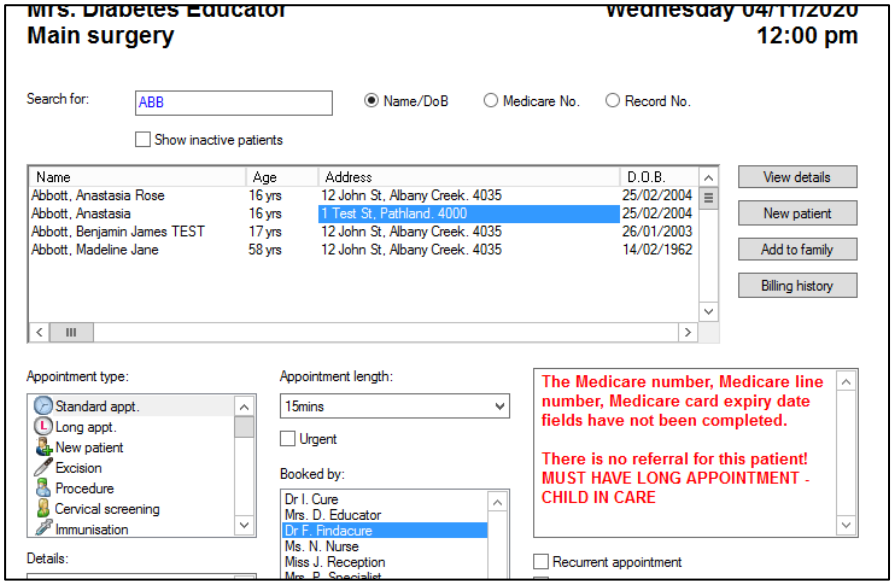


Instructions on setting up appointment reminder in Best Practice.

1. Open the patient file.
2. Select **Edit patient**.
3. Type reminder in the **Appointment notes** section.
4. **Save** to complete.



5. Every time this patient is being booked in an appointment; the prompt will appear.



It is recommended that you meet as a practice team to identify how in your practice you will identify and record children and young people in care.

My Health Record

Continuity of health care is a key issue for children in care, particularly when changes to their care arrangement may lead to changes in their health care provider.

The My Health Record system is an Australian government initiative, providing an online summary of an individual's key health information such as their allergies, medical conditions, medication details and pathology test results. It is a cumulative record of a person's health and pharmaceutical history that can be viewed and added to by health care providers from anywhere in Australia at any time, enabling continuity of health care and improved information sharing between health care providers.

My Health Record access and uploading.

- RACGP My Health Record, A brief guide for general practice
- My Health Record Policy Template

Uploading a shared health summary instruction sheet.

- MedicalDirector
- Best Practice

Shared health summary calculators.

- via CAT 4
- MedicalDirector
- Best Practice

It is recommended to upload a shared health summary to My Health Record after each annual health check.

ACTIVITY 1.2 – Understanding your children in care patients

The aim of this activity is to increase your understanding of the systems in your practice to assist patients who are in out of home care.

Description	Status	Action to be taken
Does your new patient information form currently have a question asking if the patient is currently living in care?	· Yes: **see action to be taken.** · No: **see action to be taken**.	Is this information entered into the patient's file? · Yes · No Who has the responsibility to ensure this information is entered? Your practice may consider adding a living arrangement and child safety service centre contact details question to your new patient form.
Does your new patient form include information required for Smart Referrals?	· Yes: continue with activity**.** · No: **see actions to be taken**.	Your practice may consider reviewing your new patient form.
Do relevant team members know how to enter an appointment reminder to ensure children in care have a long appointment booked at each visit?	· Yes: continue with activity**.** · No: **see actions to be taken**.	Refer to instructions on Pracsoft. Refer to instructions on Best Practice.
After completing **Activity 1.1** are there any unexpected findings with the number of children in care at your practice? *(Best Practice users only)*	· Yes: **see actions to be taken.** · No: continue with activity.	Please explain: *(e.g., our records indicated we did not have any children in care, but we know at least 7 children who are).*

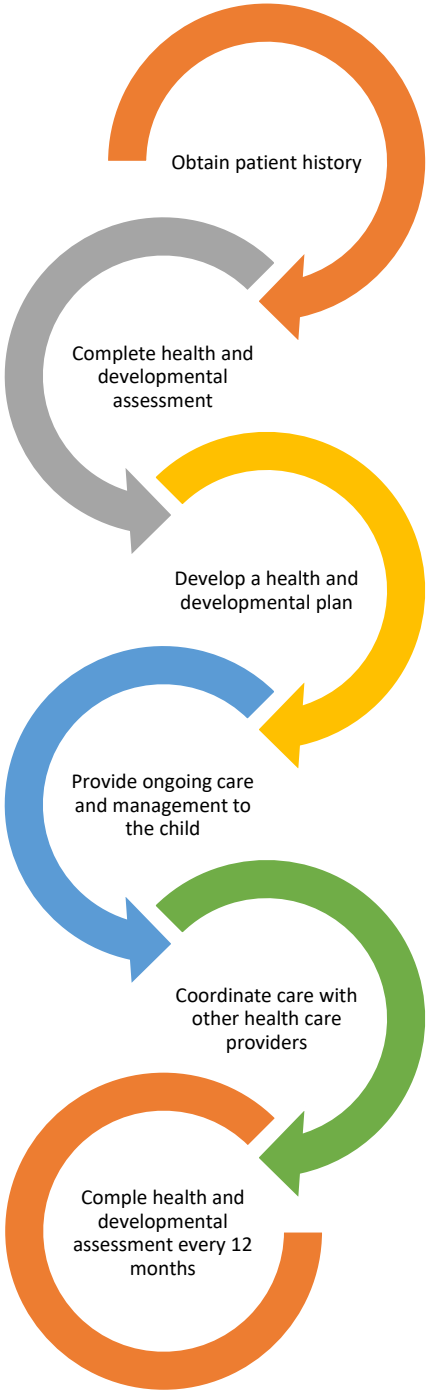
Description	Status	Action to be taken
		How will this information be communicated to the practice team?
Do you ensure all children in care have an up-to-date shared health summary?	· Yes: continue with activity. · No: **see action to be taken.**	Outline the process your practice follows to ensure My Health Records are maintained and up to date. How will this information be communicated to the practice team?
After reviewing your practice processes on recording children in care statuses, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	· Yes, **see actions to be taken** to help set your goals. · No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Reflection on **Activity 1.2**:

Practice name:	**Date:**
Team member:	

ACTIVITY 2 – CARE PATHWAYS

The assessment of children and young people in care can be complex and may require several appointments to complete. Comprehensive and coordinated health care by GPs is the ideal setting for care of vulnerable children and young people. For any child in care, it is suggested that the following pathway is followed:



Children and Young People in Care HealthPathways

Darling Downs and West Moreton PHN HealthPathways have great pathways for children and young people in care. Darling Downs and West Moreton PHN HealthPathways provide clinicians in the Darling Downs and West Moreton catchment with web-based information outlining the assessment, management and referral to other clinicians for over numerous conditions.

It is designed to be used at point of care primarily by general practitioners but is also available to specialists, nurses, allied health and other health professionals.

To access these resources please use the login credentials relevant to your region -

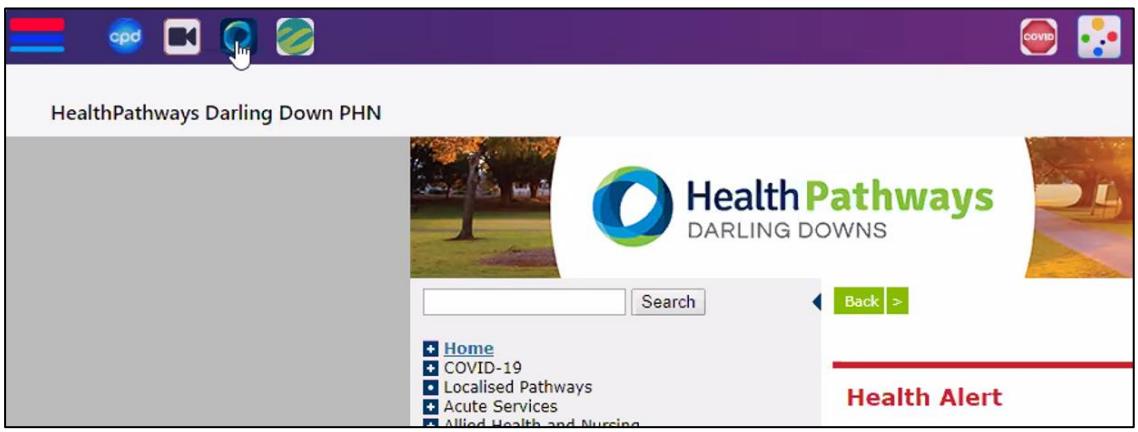
https://darlingdowns.healthpathwayscommunity.org/index.htm
Username: dduser Password: ddpassword
Link to pathway - https://darlingdowns.communityhealthpathways.org/90151.htm

https://westmoreton.communityhealthpathways.org/13454.htm
Username: wmuser Password: wmpassword
Link to pathway - https://westmoreton.communityhealthpathways.org/270446.htm

DD HealthPathways and WM HealthPathways are also available as Apps in your Pen CS Topbar software (if you have Topbar installed at your practice). If you access DD HealthPathways or WM HealthPathways via Topbar the login credentials are already embedded, and you will automatically be logged in.

Icon for DD HealthPathways in Topbar.

Icon for WM HealthPathways in Topbar.



ACTIVITY 2.1 – Accessing Healthpathways

The aim of this activity is to review relevant team members' access and use of HealthPathways.

Description	Status	Action to be taken
Do all GPs and nurses have login details for HealthPathways?	· Yes: continue with activity. · No: **see action to be taken**.	Provide login credentials to staff.
Do all GPs and nurses know how to access HealthPathways via Topbar?	· Yes: continue with activity. · No: **see actions to be taken**.	Contact DDWMPHN via email: practicesupport@ddwmphn.com.au
After reviewing your practice team's access to HealthPathways, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	· Yes, see **actions to be taken.** · No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Reflection on **Activity 2.1**:

Practice name:	**Date:**
Team member:	

Completing patient history

Understanding the patient history is important for children in care. Adverse childhood experiences are common and requires monitoring. These include:

- substance use during pregnancy
- parental mental health conditions
- socioeconomic disadvantages
- incomplete immunisation statuses.

As part of completing the patient history, check:

- supporting information regarding the child's health and relevant family history provided by Child Safety or other health providers
- Medicare registration
- My Health Record for any critical shared information
- details of any accompanying person and their role/relationship and authority.

Age-appropriate comprehensive health assessment

Perform an age-appropriate health assessment. It is important to consider a child's developmental milestones and mental health, as well as their health status.

- Complete the age-appropriate Preliminary Health Check form and/or the comprehensive health and developmental assessment (email address required to load).
- If required, consider arranging a Key Age Child Health Check with the Child Health Service for children aged up to 5 years 11 months, or perform a clinical assessment of the key domains (social emotional, communication, cognition and motor skills).

Screening tools

Over the course of the preliminary and the comprehensive Health Assessment, it is expected that the following screening tools are implemented. If they cannot be completed, perform a clinical assessment with reference to the four clinical domains (social emotional, communication, cognition, motor skills). This is critically important as the Out of Home Care (OoHC) Health Assessment templates rely on the outcomes of the tools for the holistic assessment, particularly the mental health aspect.

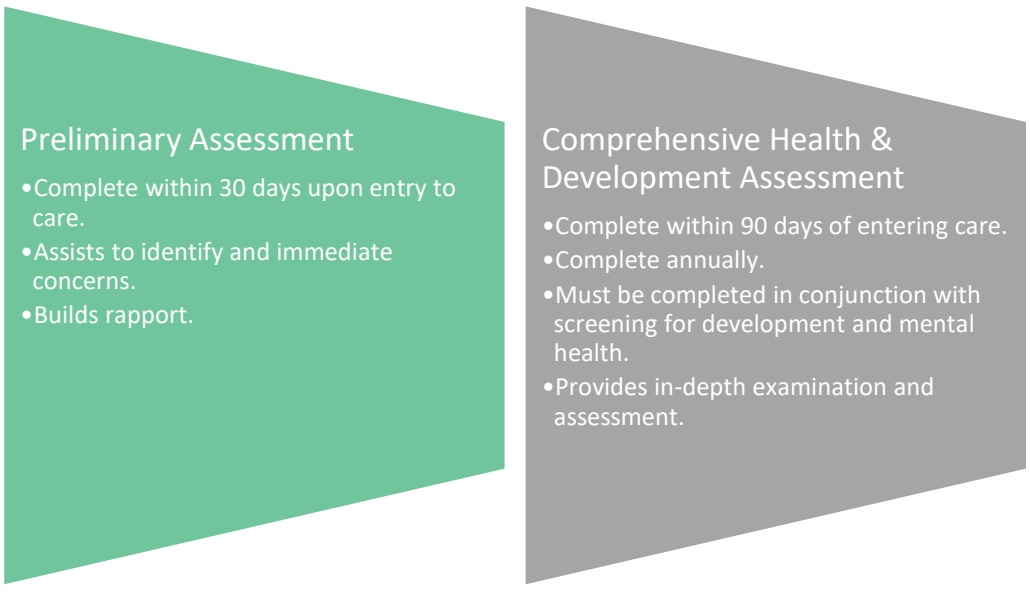
Screening tool name	Age range	Description

Strengths and Difficulties Questionnaire (SDQ)	2 – 17 years	This is a brief behavioural screening questionnaire. It exists in several versions to meet the needs of researchers, clinicians and educationalists. Each version includes between one and three of the following components:
		• Psychological attributes including: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behaviour.
		• Impact supplement including: chronicity, distress, social impairment, and burden to others.
		• Follow-up questions including:
		  ○ has the intervention reduced problems? and
		  ○ has the intervention helped in other ways?
		This is a free questionnaire available in multiple languages.

Parents' Evaluation of Developmental Status (PEDS)	Birth to 8 years	• For detecting developmental and behavioural problems in children via parent report. • The tool covers the following nine domains: global/cognitive; expressive language and articulation; receptive language; fine motor; gross motor; behaviour; social/emotional; self-help and school readiness.
Ages and Stages Questionnaire (ASQ)	3 months to 6 years	• The tool comprises a series of 19 separate questionnaires for different ages grouped by months of age, with 30 items per questionnaire. Each questionnaire includes clear drawings and simple directions to help parents to identify their child's skills. • The ASQ provides developmental information in five key domains: communication; gross motor skills; fine motor skills; problem solving and personal/social skills. • The tool requires a license to be purchased. This is a paid resource, or patient can be referred to child health nurse for completion.
Health of the Nation Outcome Scales – Child and Adolescent (HoNOSCA)	12+ years	• HoNOSCA is a clinician rated instrument comprising 15 simple scales measuring behaviour, impairment, symptoms, social problems and information problems.

Screening tool name	Age range	Description
		• Training is freely available online via Australian Mental Health Outcomes and Classification Network.
The HEEADSSS psychosocial interview for adolescents	12+ years	The HEEADSSS interview is a useful screening tool, that can also aide engagement. It includes: home, education & employment, eating and exercise, activities, drugs and alcohol, sexuality and gender, suicide, depression and self-harm and safety. This is built into the 12+ health assessment template.
CRAFFT	12 to 18 years	The CRAFFT interview is an efficient and effective health screening tool designed to identify substance use, substance-related riding/driving risk, and substance use disorder.
Pediatric Symptom Checklist	6 to 16 years	• Is a psychosocial screen designed to facilitate the recognition of cognitive, emotional, and behavioral problems so that appropriate interventions can be initiated as early as possible. • There is a parent completed version, plus a child self-report.

Assessments



Children's Health Qld has templates available for preliminary and comprehensive health checks and assessments. These templates are available in PDF and can also be uploaded as templates into Medical Director and Best Practice.

ACTIVITY 2.2 – Templates available in your practice

The aim of this activity is to review the availability of preliminary health checks and assessments in your practice.

Description	Status	Action to be taken
Do you know where to access preliminary health checks and assessment templates for children and young people in care?	· Yes: continue with activity. · No: **see action to be taken**.	Obtain templates from Children's Health Qld.
Have the templates been included in your practice's clinical software package?	· Yes: continue with activity. · No: **see actions to be taken**.	See instructions.
Are relevant team members aware of the availability of the templates?	· Yes: continue with activity. · No: **see actions to be taken**.	Communicate to the team the availability of the templates.
After reviewing your practice team's access to assessment templates, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	· Yes, **see actions to be taken.** · No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Reflection on **Activity 2.2**:

Practice name:	**Date:**
Team member:	

Aboriginal and Torres Strait Islander health check (MBS item 715)

As part of the Medicare Benefit Schedule (MBS), there is an Aboriginal and Torres Strait Islander Peoples Health Assessment. This assessment is available for the following population:

- children between ages of 0 and 14 years
- adults between the ages of 15 and 54 years
- older people over the age of 55 years.

Please refer to activity 4 – children and young people in care and Medicare, for more information on the MBS criteria.

The National guide to a preventive health assessments for Aboriginal and Torres Strait Islander people provides lifecycle charts for children and youth. These are great resources to assist in identifying milestones and prevention activities and health promotion to review at various ages.

Health management plan

It is recommended that all children in care should have a health management plan. This should be reviewed at the annual Comprehensive health and development assessment. Key elements of the plan should be uploaded to the child's My Health Record.

- Key component to facilitate coordination and continuity of care through a collaborative approach.
- The health record, together with relevant referrals and a schedule of future assessments or treatment will constitute the necessary heath management plan.
- The health record should be updated regularly and move with the child. Carers (and where appropriate the child or young person) should also have access to the health record to ensure effective coordination.
- Provide a copy of the assessment and plan to child safety, carer and other health professionals.

Developmental assessments

If you have developmental concerns, please refer to the HealthPathways **'Child and Youth Health'**.

Navigate to HealthPathways.

ACTIVITY 2.3 – Checklist to review access to screening tools

Complete the checklist below to review your practice's access to screening tools.

Questions to consider	Status	Action to be taken
Do relevant team members have access to the National Guide lifecycle charts?	· Yes, continue with the activity. · No, **see actions to be taken.**	Guidelines and information can be obtained child and youth.
Do relevant team members know where to access the health assessment templates?	· Yes, continue with the activity. · No, **see actions to be taken.**	Obtain templates from CHQ. Have these templates been uploaded onto your clinical software package? · Yes · No
Do relevant team members have access to screening tools?	· Yes, continue with the activity. · No, **see actions to be taken.**	Refer to screening tools. How will this information be made available to all team members?
After reviewing your practice's access to National Guide lifecycle charts, health assessment templates and screening questionnaires, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	· Yes, **see actions to be taken.** · No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Reflection on **Activity 2.3**:

Practice name:	**Date:**
Team member:	

Immunisations schedules

The Immunisation Schedule Queensland is a series of immunisations given at specific times throughout a person's life. Children in care may have lower immunisation rates, so it is important to check each child has received all of their vaccinations. Schedules are available:

- Immunisation Schedule Queensland 2020 Adolescents & Adults
- Immunisation Schedule Queensland 2020 Children

Important: always check the Australian Immunisation Record (AIR) prior to giving any vaccinations and always notify all vaccinations given to patients to AIR.

Australian Immunisation Register (AIR) for vaccination service providers

The (AIR) is a national register that records all vaccines given to all people in Australia.

The AIR includes vaccines given:

- under the National Immunisation Program (NIP)
- through school programs
- privately, such as for flu or travel.

ACTIVITY 2.4 – Using AIR in general practice

The aim of this activity is to ensure the relevant staff in your practice know how to use AIR.

Details	Status	Action to be taken
Are all GPs in your practice registered to use PRODA?	· Yes, continue with activity. · No, **see actions to be taken.**	See information on registering for an individual account. See information on registering an organisation.
Do relevant team members know how to login to AIR via PRODA?	· Yes, continue with activity. · No, **see actions to be taken.**	See video: How to login to AIR via PRODA.
Do relevant staff know they can search for an immunisation history for individual patients on AIR?	· Yes, continue with activity. · No, **see actions to be taken.**	See information: How to find and interpret immunisation records on AIR.
Do relevant staff know how to record immunisation encounters on AIR?	· Yes, continue with activity. · No, **see actions to be taken.**	See information: How to record immunisation encounters on AIR.
Do relevant staff know how to lodge a medical exemption on AIR?	· Yes, continue with activity. · No, see actions to be taken.	See information on How to lodge a medical exemption on AIR.
Does your practice follow up patients on the due/overdue report to ensure they are immunised?	· Yes, continue with the activity. · No, **see actions to be taken.**	Consider adding patients to the practice recall and reminder system. Contact patient to organise appointment time.
Do you know that patients can view their immunisation history statement from AIR	· Yes, continue with the activity.	See information on How to get an immunisation history statement.

Details	Status	Action to be taken
	· No, **see actions to be taken.**	
Do you know the contact details of AIR?	· Yes, continue with the activity. · No, **see actions to be taken.**	AIR contact number is 1800 673 809.
After reviewing your processes for reporting to AIR, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	· Yes, **see actions to be taken.** · No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Reflection on **Activity 2.4**:

Practice name:	**Date:**
Team member:	

ACTIVITY 3 – INTEGRATED CARE

Integrated care is the provision of care in the broadest sense – physical, psychological and social – which is oriented around the needs of children, young people and families, and designed and delivered in partnership with them.

ACTIVITY 3.1 – Identify roles for managing children in care within your practice

The aim of this activity is to identify roles and responsibilities within your practice when completing health checks and assessments on children and youth in out of home care.

Consider how best to use your practice staff to provide optimum care and how this will impact on the workload and appointment system.

Activity	Nurse	GP	Practice Manager	Receptionist
Update guardian details including child safety service centre contact details.				
Updating allergies and reactions.				
Updating any relevant history including birth history, medical history, social and family history.				
Reviewing immunisation history and identifying and due/overdue immunisations.				
Height, weight, BMI and head circumference.				
Vision assessment.				
Hearing and communication assessment.				
Review diet/healthy eating				
Review physical activity and exercise tolerance				
Review smoking and alcohol intake				
Check mental health status and offer support services				
Provide self-care education				

Activity	Nurse	GP	Practice Manager	Receptionist
Organise appointment for oral health check				
Assess eligibility for MBS items (GP management plan, team care arrangements, Aboriginal and Torres Strait Islander health assessment, mental health treatment plan)				
Consider chronic diseases (diabetes, anxiety, depression, asthma)				
Review medications				
Assess need for specialist referral				
Uploading to My Health Record				
Scheduling recalls/reminders				
Recording child in care status in the patient's file				
Recording appointment reminder in patient's file to ensure long appointments are made				

Reflection on **Activity 3.1**:

Practice name:	**Date:**
Team member:	

Importance of working as a team when managing children and youth in care

It is important to collaborate and work with other team members involved in caring for and managing children and young people in out of home care. This includes the child safety officer, other health professionals, carer, parent and child. If everyone is involved with developing a shared plan, everyone is working towards the same goal. It is also important to share any non-routine health and referral information with the child safety officer.

Contacting Child Safety

The carer can provide the contact details of the Child Safety Service Centre that holds case management. The contact details are available here and the administration staff will put you in contact with the current child safety officer for the child or the team leader. Direct communication with Child Safety supports the health needs of the child and greater outcomes. Health plans, as recommended by primary care, can be embedded into the case plan and goals for the child.

Collaborating with community child health nurse

It is recommended that under school age children see the community child health nurse for every recommended developmental check at the following ages:

- 0-4 weeks
- 6-8 weeks
- 4 months
- 6 months
- 12 months
- 18 months
- 2 ½ to 3 ½ years
- 4-6 years.

It is recommended that you meet as a practice team to discuss how you currently collaborate with key members involved with caring for children and young people in care.

Referral for oral health checks

Darling Downs and West Moreton Oral Health Services

It is recommended that all children and young people in care receive 6 monthly dental checks. This should commence from first tooth.

For children to be eligible to receive publicly funded dental services in Queensland they must be a Queensland resident and be under the guardianship of the Director-General, Department of Communities, **Child Safety** and Disability Services.

These services are available from:

West Moreton

Contact the Child and Adolescent Oral Health Service Centre on **1300 763 246.**

Monday to Friday
8am and 3pm

Or contact our Oral Health Contact Centre on **1300 300 850** (excluding public holidays).

Monday to Thursday
8am and 3pm

Friday
8am to 2pm

Darling Downs

Toowoomba Hospital Dental Clinic	For appointments at any of these clinics please call on **1300 082 662.**
Dalby Dental Clinic	
Goondiwindi Dental Clinic	
Stanthorpe Dental Clinic	
Warwick Dental Clinic	
Kingaroy Dental Clinic	

ACTIVITY 4 - CHILDREN & YOUNG PEOPLE IN CARE AND MEDICARE

A range of MBS services provided by GPs are available for children and young people in care. These include GP general consultations, a range of health assessment services, and chronic disease management services accessed through Chronic Disease Management Plans (CDMP) or Mental Health Treatment Plans (MHTP). GPs make a clinical assessment of a patient's needs to determine which service(s) would be most appropriate, in accordance with the MBS regulations.

Aboriginal and Torres Strait Islander health practitioners, health workers and practice nurses may assist with aspects of the health assessment and chronic disease management services, under the supervision of a GP.

CDMPs and MHTPs may involve referral to other allied health practitioners as specified under the MBS regulations.

Group of MBS items available to GPs to meet the primary healthcare needs of children and young people in care.

MBS item group	MBS item number	Preliminary health check	Comprehensive health and development assessment	Development of a health management plan	Ongoing assessment and monitoring
Group A1- General Practitioner Attendances to which no other item applies	Level B - 23	√			
	Level C – 36	√	√	√	√
	Level D - 44	√	√	√	√
Group A14 – Health Assessments	Aboriginal and Torres Strait Islander (715)	√	√	√	√
	Children with an intellectual disability (701, 703, 705, 707)	√	√	√	√
	Refugees or other humanitarian entrants (701, 703, 705, 7070)	√	√		
Group A15 – Chronic Disease Management	Preparation of GP Management Plan (721)			√	√
	Coordination of Team Care Arrangements (723)			√	√

MBS item group	MBS item number	Preliminary health check	Comprehensive health and development assessment	Development of a health management plan	Ongoing assessment and monitoring
	Review of GP Management Plan and/or Team Care Arrangements (732)				√
	Contribution to or review of a multidisciplinary care plan prepared by another provider (729)			√	√
Group A20 – GP Mental Health Treatment	Preparation of GP Mental Health Treatment Plan (2700, 2701, 2715, 2717)			√	√
	Review of GP Mental Health Treatment Plan (2712)				√
	GP Mental Health Consultation (2713)				√
Group M12 – services provided by practice nurse or Aboriginal health practitioner on behalf of a Medical Practitioner	Chronic disease service (10997)				√

Please note: corresponding items for Other Medical Practitioners (not vocationally registered) can be found on MBS Online.

This list is to be used as a ***guide only***, practitioners are advised to check MBS item descriptors and explanatory notes at MBS Online. There may be other items that are suitable at each stage of the assessment and care of children and young people in care.

Health assessments (MBS items 701-707 and 715)

These health assessments are only available for some children and young people in care e.g. those with an intellectual disability.

There are time-based MBS health assessment items: 701 (brief), 703 (standard), 705 (long) 707 (prolonged) and 715 (Aboriginal and/or Torres Strait Islander)

More information can be found at MBS Online.

Additional health assessment resources

- An education guide is available from Department of Human Services
- RACGP – Guide for prevention in General Practice (Red Book)
- The Department of Health – Medicare Health Assessment Resource Kit
- RACGP – Conducting quality health assessments in General Practice.

Chronic disease management plans (MBS items 721, 723, 732)

There are two types of plans that can be prepared by the patient's regular General Practitioner (GP) for Chronic Disease Management (CDM): GP Management Plans (GPMP); and Team Care Arrangements (TCAs)

These plans are for:

- patients with a chronic (or terminal) medical condition (i.e. condition has been present or likely to be present for six months) – GPMP (GP only care planning)
- patients who have complex care needs and require treatment from two or more other health care providers - GPMP and TCA (GP and multidisciplinary team care planning).

If the patient has both a GPMP and TCAs prepared, they may be eligible for Medicare rebates for certain allied health services.

The practice nurse can provide support and monitoring between visits via MBS item number 10997.

Eligibility: whilst the MBS criteria *does not* outline that children and young people in care are eligible for a chronic disease management plan, the following response has been received from AskMBS: *A Chronic Disease Management Plan could be justifiable for a child that has been put in foster care due to neglect, with no further diagnoses, but requires assistance with OT/physio/speech/other as they are behind on their milestones. However, please note that you will need to use your clinical judgement for each individual patient, in consideration of their circumstance, to ensure that the CDM service is appropriate.*

It is advisable that GPs ensure they are meeting the MBS criteria prior to claiming any MBS items.

Referrals for allied health services

If the patient has both a GPMP and TCA prepared, they may be eligible for Medicare rebates for specific individual allied health services that the GP has identified as part of patient care. The need for these services must be directly related to the chronic (or terminal) medical condition.

Resources for chronic disease plans

- Q&A on Chronic Disease plans
- Medicare Chronic Disease Management Resources including case studies.

Training modules

- GP Management Plans (GPMP)
- Team Care Arrangements (TCA)
- Allied Health Initiative (AHI) for GPs
- Multidisciplinary Case Conferences.

Mental health and Medicare

There are several Medicare item numbers available for GPs to claim for mental health related consultations. Always refer to the MBS for full details. The item numbers include:

Item description	Medicare criteria	Frequency of claiming
Mental health consultation (MBS item 2713)	Mental health consultation lasting at least 20 minutes. To claim this, the patient does not need to be on a mental health plan	No limits to the number of times this item number is claimed
Mental health plan (MBS items 2700, 2701, 2715 or 2717)	The mental health plan must include documenting the (results of assessment, patient needs, goals and actions, referrals and required treatment/services, and review date) in the patient's GP mental health treatment plan.	A new plan may be completed after 12 months if clinically required and if the person meets eligibility criteria. Full details of the criteria can be found here.
Review mental health plan (MBS item 2712)	The review item is a key component for assessing and managing the patient's progress once a GP mental health treatment plan has been prepared, along with ongoing management through the GP mental health treatment consultation.	Can be claimed every three months or at least four weeks after claiming the mental health plan item number.

More information about item numbers is available at Education guide for Mental Health Care.

Temporary telehealth item numbers

During the COVID-19 outbreak, the Australian Government have provided temporary telehealth item numbers. Please review the current telehealth numbers available on the MBS fact sheet.

Activity 4.1 – Checklist for reflection on available MBS item numbers

Complete the checklist below which will assist you to review the various item numbers available for children and young people in care.

Description	Status	Action to be taken
After reviewing the list of MBS item numbers available, are there any gaps identified in your current claiming practices?	· Yes**, see action to be taken.** · No – continue with activity.	Please explain: (*e.g., have not claimed MBS item 715 as frequently as we could*). How will this information be communicated to the practice team?
Does the practice have a system for ensuring the correct MBS item numbers are claimed?	· Yes, continue with activity. · No – **see actions to be taken.**	Can GPs review their day sheet of billings? Does the GP communicate the item number to bill to reception? · Yes · No
Does the practice have a system for tracking MBS item number claiming?	· Yes, continue with activity. · No, **see actions to be taken.**	Review reports from billing software on a regular basis – develop a system that works for you and your practice. Set reminders in your system to regularly check this.
Do you know the contact details for any MBS related questions?	· Yes, continue with activity. · No, **see actions to be taken.**	Email:askMBS@health.gov.au Provider Enquiry Line - 13 21 50

Description	Status	Action to be taken
Do relevant staff know that Medicare provide online training modules?	· Yes, continue with activity. · No, **see actions to be taken.**	More information can be obtained from Medicare Australia e-learning modules.
After reviewing the number of MBS items available for children and young people in care, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	· Yes, **see actions to be taken to help set you goals.** · No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Reflection on **Activity 4.1**:

Practice name:	**Date:**
Team member:	

Children in care and Medicare card/number

Children may not have a separate Medicare card if entry into child protection system has been recent. Some children in care may not have a Medicare number as their birth may have not been registered.

Options are:

- if you are billing a patient that has been enrolled but do not have their Medicare card, your practice can call Medicare (132 150) to get the Medicare number. You can also look up the details in HPOS.
- if the patient is not yet enrolled in Medicare, child safety can arrange this, or
- if the patient is eligible for Medicare, you can treat them and bulk bill later when you know their Medicare number.

If the patient is not eligible for Medicare, you can invoice the Child Safety service centre for the child, however, this is not ideal as there is a limited budget. The preference is for the practice to place billing on hold until Medicare options are fully pursued.

ACTIVITY 5 – REFERRAL PATHWAYS

HealthPathways

Refer to HealthPathways **'Child and Youth Health'** for full details of potential members of the multidisciplinary care team.

Navigate to HealthPathways.

National Disability Insurance Scheme (NDIS)

The NDIS is Australia's first national scheme for people with disability. It provides funding directly to individuals. It provides all people with disability with information and connections to services in their communities such as doctors, sporting clubs, support groups, libraries and schools, as well as information about what support is provided locally.

A referral or phone call as early as possible to NDIS early childhood early intervention is crucial if there are signs of developmental delays for children under 7 years.

GPs need to consider the breadth of services that are available. Children in care sometimes have Department of Child Safety, Youth and Women funded services just for them. It's important to make the most of the right service at the right time by the right provider.

Reporting child safety concerns

The Queensland Child Protection Guide (CPG) is a tool to assist professionals in their decision-making if concerns arise about a child who appears:

- to have experienced, or is likely to experience significant harm AND
- may not have a parent willing and able to protect them from harm.

The CPG will help professionals decide whether to report to the Department of Child Safety, Youth and Women (Child Safety) or refer to other service providers, to help families receive appropriate support and services in a timely manner.

GP Smart Referral

The Smart Referrals programs supports clinical and business change through the streamlined creation and management of referrals to Queensland specialist outpatient services. Smart Referrals allows those involved in patient care to better manage the patient journey, improve patient safety, and reduce specialist outpatient wait times.

Program components include GP Smart Referrals, allowing GPs to create and submit electronic referrals from existing practice software.

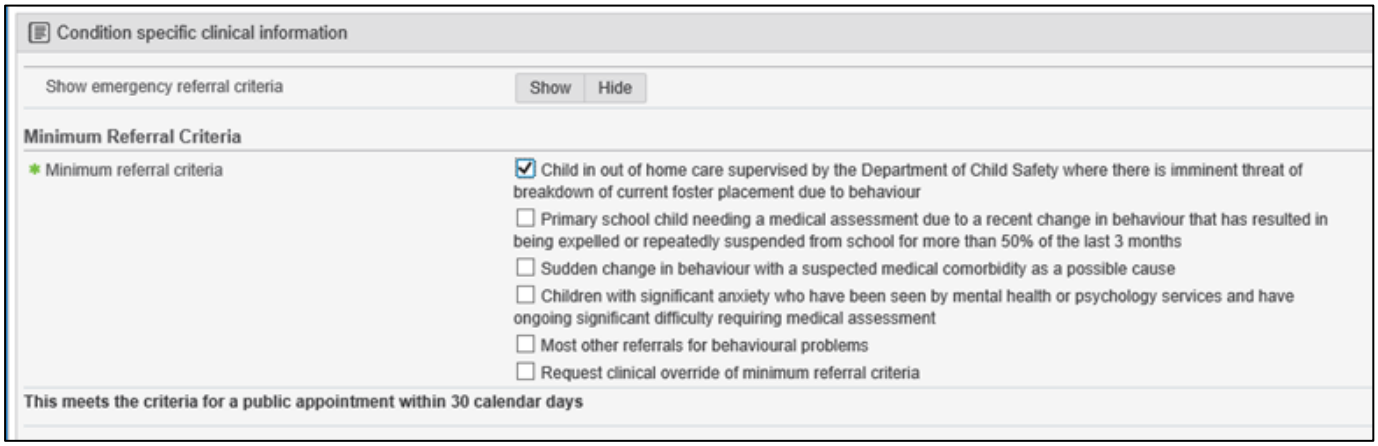
☐ Learn more about Smart Referrals from the QLD Health site HERE

☐ View Smart Referral resources and PDF Guides to installation and set up HERE

Smart Referral criteria for children and young people in out of home care

The GP Smart Referral template for a child mandates information regarding custodian/guardianship issues as well as if the patient is currently in "out of home (foster) care" *(see details below)*.

Where a GP has searched against a Clinical Prioritisation Criteria (CPC) condition, they are provided with the details of the minimum referral criteria, which is also mandatory for completion. The GP is able to clinically override minimum referral criteria and provide details as to why they have done so. Based on the CPC condition searched, and criteria information provided, the GP is provided with the expected category based on CPC criteria *(see details below).*



As with all referrals, legacy or Smart Referrals generated, it is still at the discretion of the triaging clinician as to the appropriateness of accepting and categorising a patient's presenting symptoms. Below is how this information is provided to the receiving triaging clinician.

Minimum Referral Criteria	
Minimum referral criteria	Child in out of home care supervised by the Department of Child Safety where there is imminent threat of breakdown of current foster placement due to behaviour
History and Examination	
Concerning features	Physical aggression placing family members (e.g. much younger siblings at risk)
Please provide details outlining which family members and why they may be at risk of injury	insert free text here to provide details of which family members may be at risk of injury and why
Please provide details of any risk of the foster placement breaking down due to the child's behaviour	insert free text here to provide details of any risk of the foster placement breaking down due to the child's behaviour
History	history
Pathology and Test Results	
Imaging and Reports	
Imaging performed	
Custody / Guardianship details	
Custody and Guardianship Issue exists regarding this patient?	Yes
Custody / Guardianship details	Provide details of custody or guardianship issue
Is the child in out of home (Foster) care?	Yes
Name of the Child Safety Service Centre	Name of Child Safety Service Centre
Clinical pathway selection search term	
Behavioural problem in a child < 6 years (General Paediatrics)	

Patient Contacts / Next of Kin

Name	Contact	Address	Relationship
Carer Name (Patient's Nominated Contact)	**Phone:** Carer Number (Mobile Contact)	Not Provided	Carer Relationship

The GP also has an ability to provide additional free text information and context in their free text referral letter:

Referral Letter

Field	Value
Referral Letter	Dear Colleague, ...

Whilst Smart Referrals offers a platform to capture this information, the triaging and categorisation of patient referrals requires clinical decision-making and as such remains the responsibility of the triaging clinician.

Health Services Directory

Health Services Directory is a joint initiative of all Australian governments, delivered by HealthDirect Australia, to provide health professionals and consumers with access to reliable and consistent information about health services.

My Community Directory

My Community Directory lists organisations that provide services that are free or subsidised to the public in thousands of locations across Australia. These services are organised into various Community Directories.

Activity 5.1 – Referral Pathways

Complete the checklist below in relation to Referral Pathways.

This activity is designed to raise your awareness of local referral options available for you and your patients to facilitate co-ordinated and therefore optimal care.

Description	Status	Action to be taken
Do all GPs and Nurses have access to HealthPathways, either Darling Downs and/or West Moreton?	· Yes, continue with the activity. · No, see **Action to be taken.**	Register on the appropriate HealthPathways page to request access.
Do all relevant team members know where to find more information about the NDIS?	· Yes, continue with the activity. · No, see **Action to be taken.**	See information.
Do all relevant team members know where to obtain information about reporting child safety concerns?	· Yes, continue with the activity. · No, see **Action to be taken.**	Refer to the Queensland Child Protection Guide.
Are all the GPs in your practice registered for Smart Referrals?	· Yes, continue with the activity. · No, see **Action to be taken.**	To register for Smart Referrals please contact practicesupport@ddwmphn.com.au
Do you know who to contact if you have any issues with Smart Referrals?	· Yes, continue with the activity. · No, see **Action to be taken.**	The Darling Downs and West Moreton PHN or 07 4615 0900 or email practicesupport@ddwmphn.com.au
Do all GPs know to include details about out of home care status on referral?	· Yes, continue with the activity. · No, see **Action to be taken.**	Discuss the importance of including details about out-of-home care status on referrals at your next team meeting.

Description	Status	Action to be taken
How will you communicate information, so clinicians know where to access details on referring a patient to specialist services?	What is the practice plan for communicating referral information?	
After reviewing your practice Referral Pathways, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	· Yes, see **actions to be taken.** · No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Reflection on **Activity 5.1**:

Practice name:	**Date:**
Team member:	

ACTIVITY 6 – POLICY AND PROCEDURES

It is important that the practice reviews its policy and procedure manual, to ensure relevant documentation is in place and up to date. It is recommended that the following policy and procedures are in place:

- trauma informed care throughout policies and procedures
- GP self-care
- transfer of patient care
- patients' rights and responsibilities
- mental health first aid.

Activity 6.1 – Policies and Procedures

*Complete the below table to gather information on your **current** policies and procedures relating to children and young people in care.*

Activity 6.1 – Review Policy & Procedures				
Does the practice have a policy and procedure for the following?	**Policy up to date ***	**Policy needs reviewing**	**Who will review or update?**	**Date completed**
Trauma informed care	□	□		
GP self-care (http://www.dhas.org.au/)	□	□		
Transfer of patient care	□	□		
Patients' rights and responsibilities	□	□		
Mental Health first aid	□	□		

Reflection on **Activity 6.1**:

Practice name:	**Date:**
Team member:	

Activity 6.2 – Policies and procedures review

The aim of this activity is to complete a PDSA on any policy and procedures that need updating in your practice.

Description	Status	Action to be taken
After reviewing your relevant policy and procedures, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	· Yes: **see actions to be taken.** · No: you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Reflection on **Activity 6.2**:

Practice name:	**Date:**
Team member:	

ACTIVITY 7 – RECALLS AND REMINDERS

Recalls and reminders for children and young people in care

Many children in care experience multiple placement changes. From a study conducted on 77 children:

- 40% of the sample had experienced between two and five placements
- 14% had experienced between six and 10 placements
- 32% had had more than 11 placements.[8]

To ensure the patient receives any notification in relation to a recall or reminder, it is important that the practice provides details to the carer and child safety officer.

Activity 7.1 – Reminder system

The aim of this activity is to review your practices reminder system to assist children and young people in care.

Description	Status	Action to be taken
Is consent obtained from patients to be included in the practice's reminder system?	· Yes, how is this done? · No, **see action to be taken.**	Include a section on new patient information sheet about consent to participate in reminder system. Clinicians ask patients prior to placing them on reminder system.
How does the practice record if a patient **DOES NOT** wish to be contacted offering reminder appointments?	Provide information. How is this communicated to the practice team?	
Are recalls and reminders for children in care sent to multiple recipients (including child safety, carer etc) to ensure patient is notified?	· Yes, continue with activity. · No, **see action to be taken.**	Discuss this at your next team meeting.
Are annual comprehensive health and development assessment reminders added to each patient who is living in care?	· Yes, continue with activity.	Develop a system in your practice to ensure annual reminders are added to each patient's file.

[8] https://aifs.gov.au/cfca/publications/children-care

Description	Status	Action to be taken
	· No, **see action to be taken.**	
Is there a system to identify in the appointment book when a patient is coming in for a reminder appointment?	· Yes, continue with activity. · No, **see action to be taken.**	Use of a symbol in the appointment book to identify type of appointment.
Is there a process for acting on or removing outstanding reminders? (e.g., patients fail to attend, reminder no longer needed).	· Yes, continue with activity. · No, **see action to be taken.**	GP education on removing reminders. Document practice process on removing reminders.
After reviewing your practice recall and reminder system, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	· Yes, **see actions to be taken.** · No, you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Reflection on **Activity 7.1**:

Practice name:	**Date:**
Team member:	

ACTIVITY 8 – RESOURCES

Resources for health professionals

The following are credible sources for resources, webinars, practice guides and peer learnings related to children and young people, with some specific to children in care. These are aimed at health professionals including GPs, thus often have CPD points. All are free, with many webinars available on demand and there are links to e-newsletters for new resources/webinars. Current as of December 2020.

- National Clinical Assessment Framework for children and young people in out-of-home care
- Out of Home Care toolbox.

RACGP

- RACGP and Emerging Minds Child Mental Health Series covering adverse childhood experiences (ACEs), trauma-informed care, social and emotional development, and relationships and attachment.
- GP e-learning and face-to-face. Topic examples:
    - Youth mental health skills training
    - Eating disorders
    - Using e-mental health resources to help teens
    - Infant mental health
    - Youth AOD
    - Supporting children's resilience.

- Practice Guidelines for Treatment of Complex Trauma and Trauma Informed Care and Service Delivery – Blue Knot Foundation

- Project ECHO (Children's Health Qld) Video link - Interactive on-line multidisciplinary education and case presentations to improve knowledge and capability of GPs and health professionals. Offered for free throughout the year at certain times/dates.

- Emerging Minds – National Workforce Centre for Child Mental Health
    - Newsletter for upcoming webinars
    - Webinar and Online Training examples- many are RACGP accredited, therefore aimed at GPs and health professionals, and are between 1-3 hours:
        - Understanding child mental Health
        - The impact of trauma on the child
        - Supporting children's resilience in general practice
    - Resources:
        - Toolkit for working with Aboriginal and Torres Strait Islander children and families.
        - Trauma topic page with factsheets on trauma responses by age.

- Mental Health Professionals Network

- Newsletter for upcoming events online and local face-to-face networks
- Webinar topic examples:
  - Suicide ideation in primary school aged children
  - Self-Care for professionals
  - Recognising and managing oppositional defiance disorder

Aboriginal and Torres Strait Islander health

- Safer Healthcare for Australia's First Peoples – free 6 hour self-paced online course for health professionals, Griffith University
- RACGP guides on Aboriginal and Torres Strait Islander Health
- Healing Foundation.

Evolve Therapeutic Services

- Local Evolve services may hold free training in trauma-informed care and other relevant topics for a variety of audiences.
- Online course on Attachment - 30-90minutes to complete. Suitable for QH staff, GPs, foster agencies, CSOs etc.
- Online course on Foundations of Trauma (available late 2020).

Children's Health Qld

- Dream Big, Act Big for Kids: Tools and resources to educate frontline workers on the social determinants of health to improve children's health and wellbeing:
  - 1st Ed. Adverse Childhood experiences - self-reflection tools, action plans, TED talks, research.

Infant mental health

- Qld Centre of Perinatal and Infant Mental Health resources, services and programs
- Newsletter for upcoming webinars, training and research.

General information on the Child protection system

- Department of Child Safety, Youth and Women
- Family and child connect
- Medical decision-making guide for health professionals
- Information sharing guidelines
- Regional child safety offices may be able to arrange in-services.

The Queensland Health Viewer – The Viewer

The Health Provider Portal (HPP) service provides a summary patient healthcare details to registered and authenticated health practitioners. All information on display is provided via secure tunnel access to Queensland Health's read-only clinical application, The Viewer. This read-only online access will allow GPs to view public hospital information including appointment records, radiology and laboratory results, treatment and discharge summaries, and demographic and medication details.

☐ Learn all about The Viewer and FAQs HERE

☐ Already registered? Access The Viewer HERE

☐ Email the team: connectingqld@health.qld.gov.au

My Health Record

It is important to upload a Shared Health Summary (SHS) to the My Health Record of a patient with a chronic or complex condition to ensure continuity of care throughout their healthcare journey and ensure practice eHealth Practice Incentive Payment (ePIP) eligibility criteria are met.

☐ See cheat sheets on how to upload information to the My Health Record system HERE

☐ See a 1 min video on how to upload a SHS in Best Practice software HERE

☐ See a 1 min video on how to upload a SHS in Medical Director software HERE

☐ Access refresher training and eLearning modules HERE

☐ Read about eHealth on the RACGP website HERE

☐ Don't have access to the My Health Record system or claim the ePIP?

Start registration process HERE.

Electronic Prescriptions

Electronic prescriptions will improve medicines safety and provide new options and convenience for patients and their medicine supply, allowing prescribers and their patients to use an electronic Pharmaceutical Benefits Scheme (PBS) prescription.

Electronic prescriptions form part of the broader digital health and medicines safety framework. They enable the prescribing, dispensing and claiming of medicines, without the need for a paper prescription. Existing prescribing and dispensing processes will not change. Patients can still choose which pharmacy they attend to fill their prescription and can choose an electronic prescription as an alternative to a paper prescription. Paper prescriptions will still exist.

Learn more about Electronic Prescriptions from the Australian Digital Health Agency site HERE.

Activity 8.1 – Identifying health professionals with a special interest in children and young people in care

Complete this checklist to identify relevant team members who have a special interest in children and young people in care.

Description	Status	Action to be taken
Do you have any GPs in your practice who have a special interest or have done extra training in managing children and young people in care?	· Yes: **see actions to be taken.** · No: continue with activity.	List GPs who have a special interest in children and young people: _____ _____ _____ _____
Do you have any GPs in your practice who are interested in pursuing further training or professional development in this area?	· Yes: **see actions to be taken.** · No: continue with activity.	Contact the PHN to discuss available training options.
After reviewing your practice's interest in managing children and young people in care, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	· Yes: **see actions to be taken.** · No: you have completed this activity.	Refer to the MFI and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the MFI to test and measure your ideas for success.

Reflection on **Activity 8.1**:

Practice name:	**Date:**
Team member:	

Quality improvement activities using the MFI and PDSA

After completing any of the workbook activities above you may identify areas for improvement in the management of children and young people in care. Follow these steps to conduct a QI activity using the MFI and PDSA. The model consists of two parts that are of equal importance.

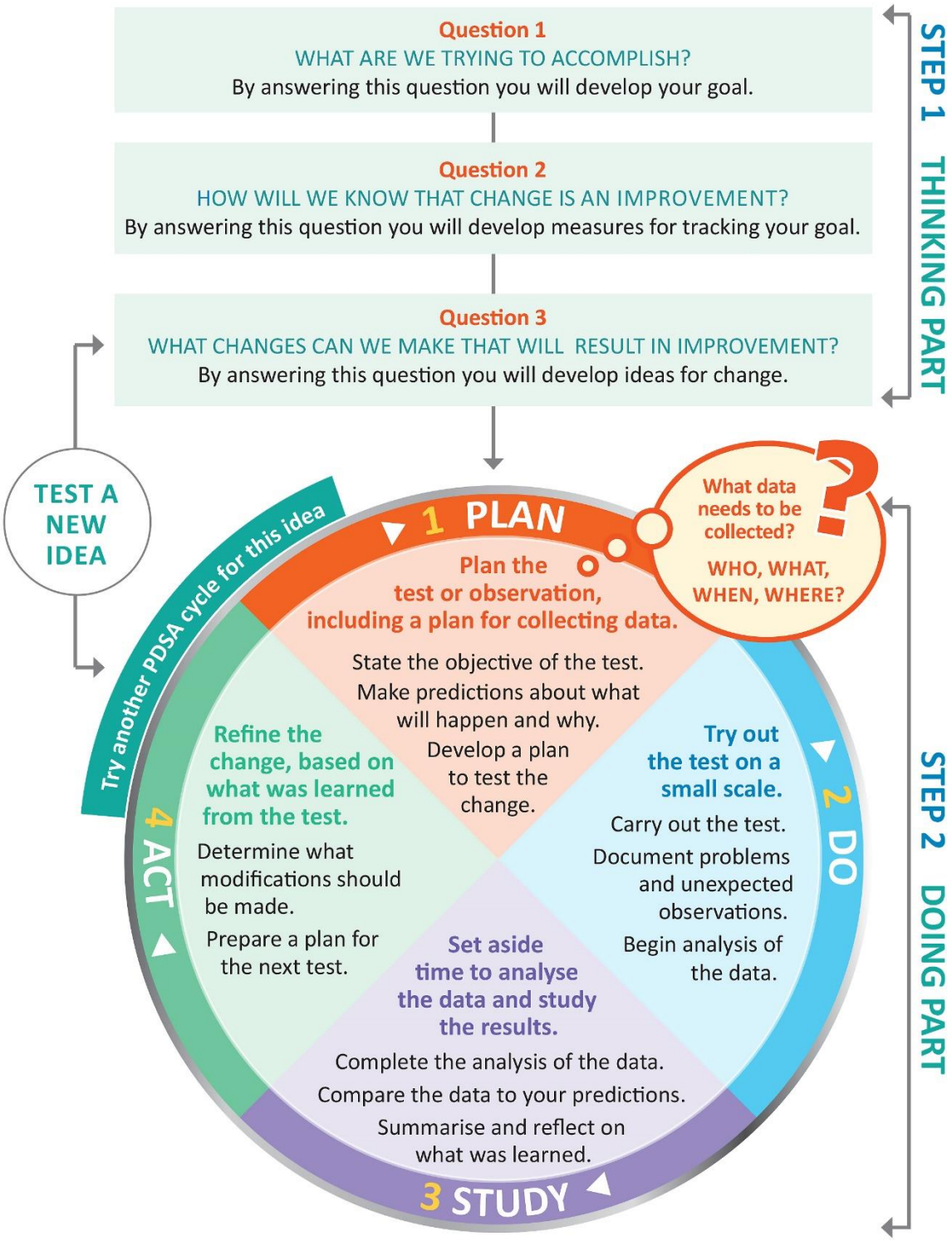
Step 1: The **'thinking'** part consists of three fundamental questions that are essential for guiding improvement work:

- What are we trying to accomplish?
- How will we know that the proposed change will be an improvement?
- What changes can we make that will lead to an improvement?

Step 2: The **'doing'** part is made up of Plan, Do, Study, Act (PDSA) cycles that will help to bring about rapid change. This includes:

- helping you test the ideas
- helping you assess whether you are achieving your desired objectives
- enabling you to confirm which changes you want to adopt permanently.

The model for improvement diagram



Source: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementTestingChanges.aspx

Model for Improvement and PDSA worksheet – EXAMPLE

Step 1: The Thinking Part - The 3 Fundamental Questions

Practice name:	**Date:**
Team member:	
Q1. What are we trying to accomplish? (Goal)	
By answering this question, you will develop your GOAL for improvement	
Our goal is to: • **Ensure all children and young people in care have an annual health assessment completed.** *This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is a S.M.A.R.T goal: Specific, Measurable, Achievable, Realistic and Time bound.* *So, for this example, a better goal statement would be:* Our S.M.A.R.T. goal is to: • **Increase the proportion of our children and young people in care, having a health assessment completed by 50% by 31 July.**	
Q2. How will you know that a change is an improvement? (Measure)	
By answering this question, you will develop MEASURES to track the achievement of your goal. *E.g., Track baseline measurement and compare results at the end of the improvement.*	
We will measure the percentage of active patients currently in care with an annual health and development assessment completed. To do this we will: A) Identify the number of active children and young people currently living in care. B) Identify the number of active children and young people currently living in care with a health and development assessment completed. B divided by A x 100 produces the percentage of patients living in care with a health and development assessment completed.	
Q3. What changes could we make that will lead to an improvement? (List your IDEAS)	
By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal. *You may wish to BRAINSTORM ideas with members of our Practice Team.*	
Our ideas for change: 1. Update practice information sheet to include living arrangements and carer contact details. Ensure this information is included in the patient's records. 2. Identify children and young people who are currently living in care and review if they have had a health assessment completed. 3. Upload health assessment templates into practice clinical software package. 4. Ensure all relevant team members are aware of how to access health and development assessment templates and understand their role within the assessment. The team selects one idea to begin testing with a PDSA cycle	

Note: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement Guide
Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

Step 2: The Doing Part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1
You will use this sheet to test an idea.

PLAN	**Describe the brainstorm idea you are planning to work on.** **(Idea)**
Plan the test, including plan for collecting data	*What exactly will you do? include what, who, when, where, predictions, and data to be collected*
Idea: Identify all children and youth currently living in care and review if they have had a health and development assessment completed **What:** Mary will conduct a search on practice software to identify patients who are currently in care. **Who:** Receptionist (Mary) **When:** Begin 20 May **Where:** at the practice in Dr Bills room **Prediction:** 30% of the children and young people currently living in care will have had a health and development assessment completed this year.	
DO	**Who is going to do what?** **(Action)**
Run the test on a small scale	*How will you measure the outcome of your change?*
45% of children and young people living in care had a health and development assessment completed in the past 12 months. This was 15% more than predicted.	
STUDY	**Does the data show a change?** **(Reflection)**
Analyse the results and compare them to your predictions	*Was the plan executed successfully?* *Did you encounter any problems or difficulty?*
Completed 20 May – Mary conducted a search on the practice software and identified that no patients appeared. It was identified that the practice was not recording this status in the correct fields. This was rectified which allowed a check on the number of health and development assessments completed.	
ACT	**Do you need to make changes to your original plan?** **(What next)** **OR Did everything go well?**
Based on what you learned from the test, plan for your next step	*If this idea was successful you may like to implement this change on a larger scale or try something new. If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance*
1. Ensure patients are identified and recorded accurately in the practice software. 2. Ensure the clinical team know how to complete the health and development assessment and management plan in the medical software. 3. Ensure all relevant templates and documentation is uploaded to My Health Record. 4. Remind the whole team that this is an area of focus for the practice.	

Repeat Step 2 for other ideas – What idea will you test next?

Model for Improvement and PDSA worksheet - TEMPLATE

Step 1: The Thinking Part - The 3 Fundamental Questions

Practice name:	**Date:**
Team member:	
Q1. What are we trying to accomplish? **(Goal)**	
By answering this question, you will develop your GOAL for improvement	
Q2. How will you know that a change is an improvement? **(Measure)**	
By answering this question, you will develop MEASURES to track the achievement of your goal. *E.g., Track baseline measurement and compare results at the end of the improvement.*	
3. What changes could we make that will lead to an improvement? **(List your IDEAS)**	
By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal. *You may wish to BRAINSTORM ideas with members of our Practice Team.*	
Idea: **Idea:** **Idea:** **Idea:**	

Note: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement plan.
Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

Step 2: The Doing Part - Plan, Do, Study, Act

You will have noted your IDEAS for testing when you answered the third Fundamental Question in Step 1
You will use this sheet to test an idea.

PLAN	**Describe the brainstorm idea you are planning to work on. (Idea)**
Plan the test, including plan for collecting data	*What exactly will you do? Include what, who, when, where, predictions and data to be collected*
DO	**Who is going to do what? (Action)**
Run the test on a small scale	*How will you measure the outcome of your change?*
STUDY	**Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions	*Was the plan executed successfully?* *Did you encounter any problems or difficulty?*
ACT	**Do you need to make changes to your original plan? (What next)** **OR Did everything go well?**
Based on what you learned from the test, plan for your next step	*If this idea was successful you may like to implement this change on a larger scale or try something new.* *If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.*

Repeat Step 2 for other ideas - What idea will you test next?

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We would like to acknowledge that some material contained in this Toolkit has been extracted from organisations including the Institute for Healthcare Improvement, the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; Best Practice; Medical Director, PenCS, and the Queensland Children's Hospital. These organisations retain copyright over their original work, and we have abided by licence terms. Referencing of material is provided throughout.

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Should the document require updating or if any errors are identified please contact the Darling Downs and West Moreton PHN via email practicesupport@ddwmphn.com.au

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