phn
NORTHERN QUEENSLAND
An Australian Government Initiative

Quality improvement toolkit for general practice

Patient population groups

Children & young people in care module
Version 2 - January 2022

Introduction

The Quality Improvement (QI) toolkit

This 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 (MFI).

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 MFI.

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

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

The MFI helps you break down your change implementation 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 of using the MFI to increase the number of health assessments completed for children and young people in care example at the end of this module.

If you would like additional support in relation to quality improvement in your practice please contact Northern Queensland Primary Health Network (NQPHN) on support@nqphn.com.au.

This icon indicates that the information relates to the ten Practice Incentive Program Quality Improvement (PIP QI) measures.

PIP QI

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

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.

How to use this toolkit

There are checklists included below that will guide you and your practice.

- use this toolkit to guide you along the journey
- set yourselves timelines to achieve your goals
- consider potential internal or external factors that could impact the activity and factor these into your planning e.g. accreditation preparation, staff leave (planned or unplanned), global pandemic, influenza vaccination season
- review your progress regularly
- if you find your process is not working and you are not seeing improvements, then review your process and start again.

For more support

Email support@nqphn.com.au.
Call (07) 4034 0300.

NQPHN acknowledges the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. We also pay our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.

Contents

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Children and 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.

Health statistics for children in care including key health issues

According to the Australian Institute of Welfare, during 2019–20:

- About 174,700 children aged 0–17 received child protection services (31 per 1,000 children).
- Aboriginal and Torres Strait Islander children were almost 8 times as likely to have received child protection services (166 per 1,000).
- Infants (aged under one) were more likely to have received child protection services than those aged 15–17 (38 per 1,000 compared with 24 respectively).
- Children from geographically remote areas had the highest rates of substantiations—children from very remote areas were more than three times as likely as those from major cities to be the subject of substantiations (24 per 1,000 compared with seven, respectively).
- Children who were the subjects of substantiations were more likely to be from lower socioeconomic areas (35% were from the lowest socioeconomic area compared with 5.9% from the highest).[1]

Primary medical issues

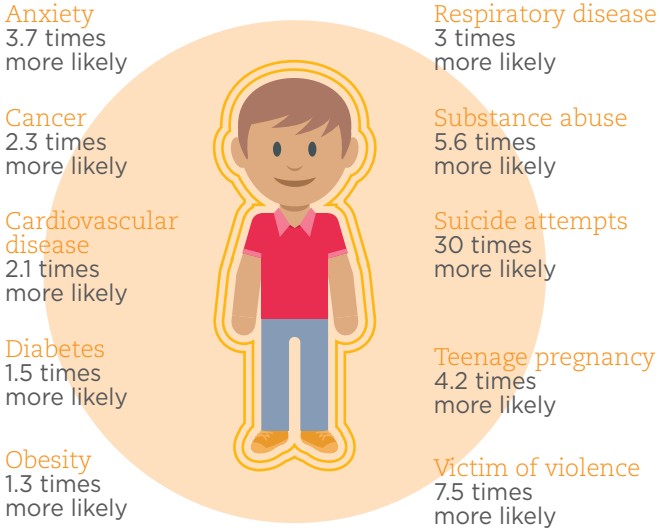
- 14% have abnormal growth
- 24% have incomplete vaccinations
- 20% have abnormal vision screening
- 28% have an abnormal hearing test
- 30% have dental problems.

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]

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]

The likelihood of health risks with four or more ACEs[4]



[1] www.aihw.gov.au/reports/australias-welfare/child-protection

[2] www.pubmed.ncbi.nlm.nih.gov/31517415/

[3] Young People in Out-of-Home Care, Health Pathways Melbourne (2018)

[4] 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.

For many First Nations peoples, health is not just the physical wellbeing of the individual but the social, emotional, and cultural wellbeing of the whole community. It is often linked to spirituality, connection with land, and the harmony of interrelating factors. There is a unique need for healing supports to address the impacts of intergenerational trauma on families that go beyond just satisfying the basic structural, materialistic needs such as housing, finances and schooling.

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, and crime).
- Developmental (developmental delay - fine motor, gross motor, speech and language, social, inattention, hyperactivity, sensory seeking, and sensory avoiding).
- Physical (incomplete vaccinations, undiagnosed hearing or visual issues, and acute medical conditions – illness, injury, chronic medical conditions, dental issues, nutrition issues, growth issues, sleep issues, sexually transmitted infections, smoking, alcohol, other substance use, and teenage pregnancy).
- School issues (disengaged from school, school non-attendance, behavioural issues, behind academically, social issues, being bullied, and bullying other kids).

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

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.

Linkages between trauma and health outcomes for children and young people in care

Some young people are at higher risk of being victimised, abused, marginalised, excluded, and/or experiencing unsafe situations that leave them vulnerable to potentially traumatic experiences. Young people who are more likely to have experienced trauma include those in care, in the juvenile justice system, those experiencing homelessness, young refugees, or asylum seekers, Aboriginal or Torres Strait Islander young people, and young people working in emergency services. However, it is very important to understand that anyone can experience trauma, regardless of their age or social/cultural background.[6]

Refer to Brisbane South PHN Trauma QI toolkit for more information and resources to assist managing patients effected by trauma.

[6] https://www.orygen.org.au/Training/Resources/Trauma/Mythbusters/Trauma-mh-yp/Trauma_and_MH_in_YP_Mythbuster?ext=

Activity 1 - Children and 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 also obtain child safety service names and contact details.

To meet the requirements of information 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 patients records

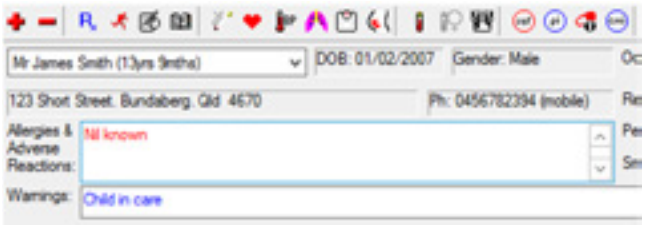
It is important for GPs and practices to easily identify patients who are currently in care. This is due to:

- 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 placement 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.

Recording information in MedicalDirector

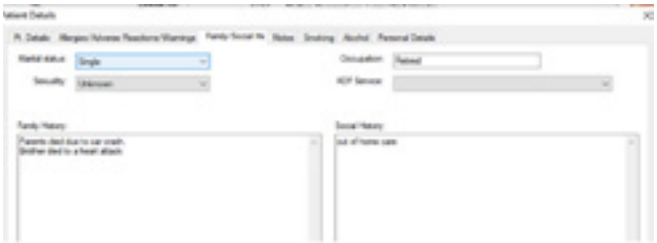
To record child in care in Warnings:

1. open patient's file
2. double click on the white box next to warnings
3. type out of home care
4. select save.



To record out-of-home care in Social History:

1. open patient's file
2. open family/social Hx
3. type out of home care
4. select save.

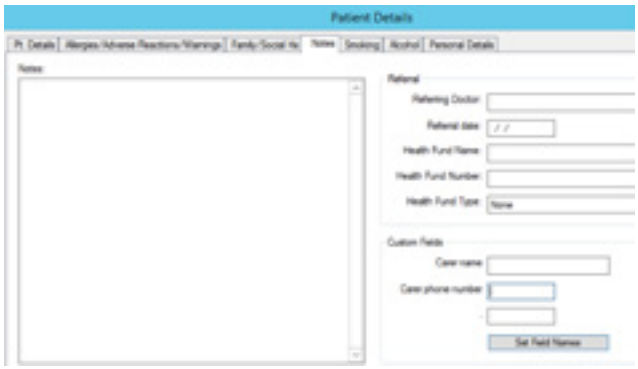


[7] https://www.racgp.org.au/advocacy/position-statements/view-all-position-statements/clinical-and-practice-management/provision-of-healthcare-to-children-and-young

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:

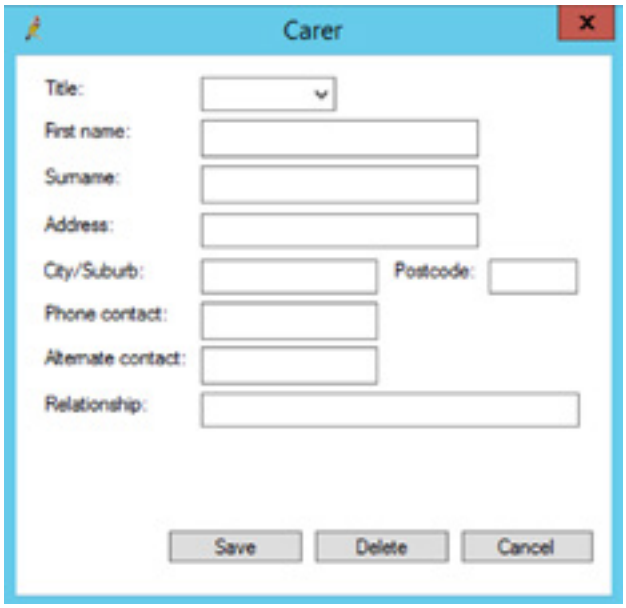
1. open patient's file
2. open the patient details screen
3. select notes
4. under the custom fields, click on set field names
5. you are then able to customise three fields to suit the needs of your practice. In the example below, we have included carer name & carer phone number
6. click save to close.



Recording information in Best Practice

To record child in care and carer details:

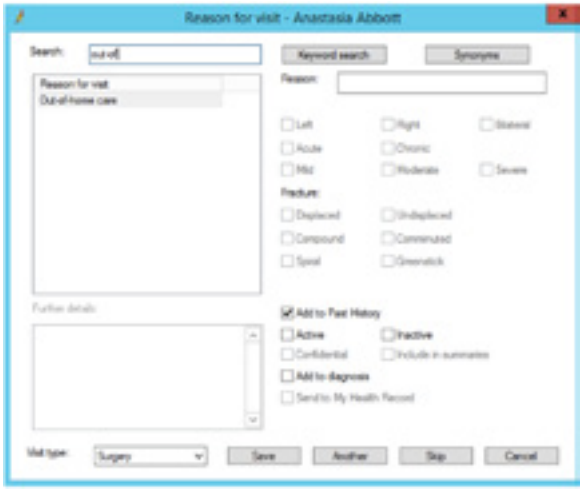
1. open patient's file
2. open the family & social history screen
3. next to on screen comment: type out of home care
4. to enter carer details, select yes to has carer
5. click on the carer details button
6. enter carer details and select save.



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).

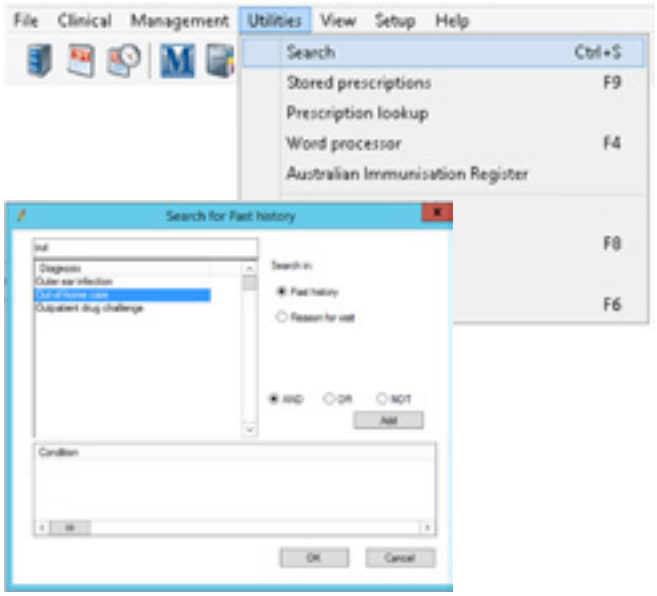
Instructions are available from Best Practice to search for this activity.

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

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.



Recording Aboriginal and Torres Strait Islander status in patient's file

It is important that practices identify and record Aboriginal and Torres Strait Islander patients. This is required to ensure:

- Patients who are eligible for participation in the PIP Indigenous Health Incentives (IHI) payment and the Pharmaceutical Benefits Scheme (PBS) co-payment, as well as other elements of the chronic disease management.
- Patients who are eligible, to access specific services aimed at reducing the disparities in health outcomes.
- Identification and thereby participation in appropriate prevention and early intervention services where needed.

Activity 1.2 – Updating Aboriginal and Torres Strait Islander status

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.

Description	Status	Action to be taken
Does your new patient form ask patient's if they identify as Aboriginal or Torres Strait Islander?	☐ Yes: continue with activity. ☐ No: see action to be taken.	Update new patient form to include this information.
Do relevant team members know how to enter Aboriginal and Torres Strait Islander status in patient's record?	☐ Yes: continue with activity. ☐ No: see action to be taken.	See instructions for Best Practice, Pracsoft or MedicalDirector.
After reviewing your identification and recording of Aboriginal and Torres Strait Islander status, 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.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Advantages and disadvantages of labeling patients

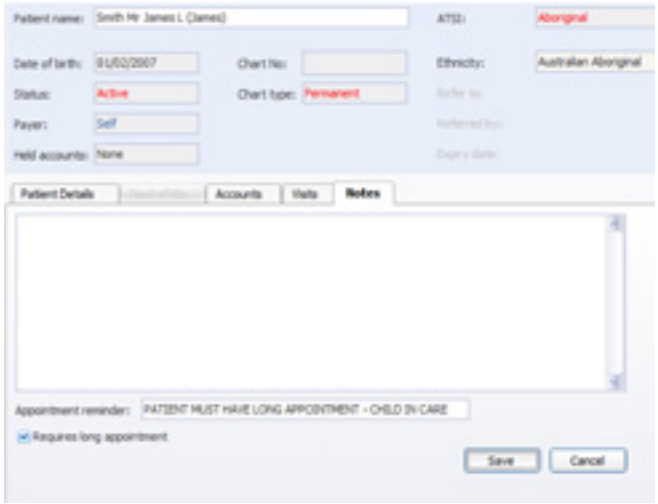
If someone is in care, it is important that it is recorded correctly so that the treating team are aware and to allow correct treatment. Any diagnosis should be discussed with the person and their carer. Just as we would record a physical health diagnosis, care of a child or young person should be recorded. If preferred, it may be marked as confidential, or inactive if no longer relevant, and the patient may choose not to upload it to My Health Record if desired.

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

Due to the fact that 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 are able to set appointment reminders in your practice software to prompt the team member at the time of booking the appointment to allow more time.

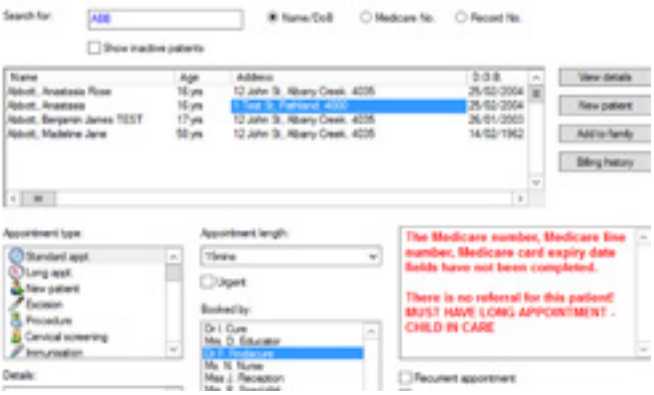
Instructions on setting up appointment reminder in Pracsoft

1. open the patient file
2. select notes
3. type reminder in the appointment reminder section
4. select requires long appointment
5. click 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. click 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 CAT4.
- MedicalDirector.
- Best Practice.

Other resources

- My Health Record and out-of-home care.
- My Health Record – children in care portal.
- A guide for foster, relative and kinship carers.

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

Activity 1.3 – 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.	Is this information entered into the patient's file? ☑ Yes ☑ No Who has the responsibility to ensure this information is entered?
	☐ No: see action to be taken.	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 action 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 action to be taken.	Refer to instructions on Pracsoft. Refer to instructions on Best Practice.
Do relevant team members prompt carers/foster or kinship carers, for information which may help at the initial visit e.g. health summary, allied health or specialist reports, pathology results.	☐ Yes: continue with activity. ☐ No: see action to be taken.	Discuss with relevant team members the importance of having all the information available for the appointment.
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: continue with activity. ☐ No: see action to be taken.	Please explain: (e.g. our records indicated we did not have any children in care, but we know at least seven children who are). 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 and are aware of controls on access to information on My Health Record?	☐ 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?
Have all team members completed the children in care training on DiscoverPHN?	☐ Yes: continue with activity. ☐ No: see action to be taken.	Refer to training module.
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.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

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:

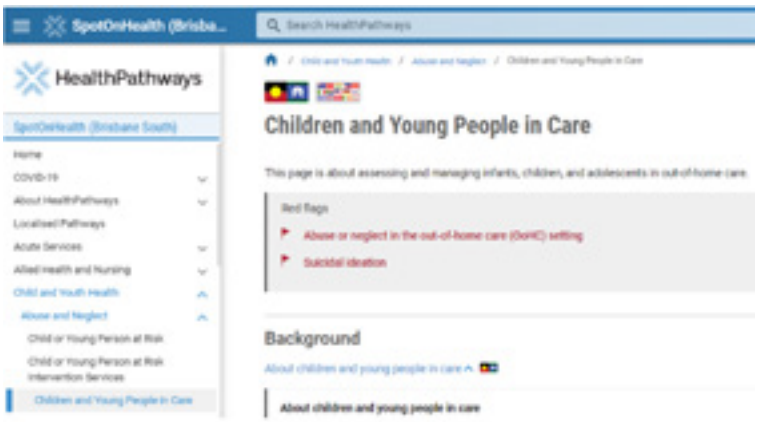
Children and Young People in Care HealthPathway

SpotOnHealth HealthPathways has a great pathway for children and young people in care. To access SpotOnHealth HealthPathways you will need to log in.

Once you have logged in, you can access the pathway by searching for “children in care” or navigating via > Child and Youth Health > Abuse and Neglect > Children and Young People in Care.

Topics included in the pathway consist of:

- background information
- assessment
- management
- referral processes
- information for health professionals and patients.



Activity 2.1 – Accessing SpotOnHealth HealthPathways

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

Description	Status	Action to be taken
Do all GPs and nurses have login details for SpotOnHealth HealthPathways?	☐ Yes: continue with activity. ☐ No: see action to be taken.	Register on the login page to request access.
Do all GPs and nurses know how to access SpotOnHealth HealthPathways via Topbar?	☐ Yes: continue with activity. ☐ No: see action to be taken.	See instructions: Or Contact BSPHN Digital Health Team via email: ehealth@bsphn.org.au.
After reviewing your practice team's access to SpotOnHealth 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 . to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

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 on both child and parent
- 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 five 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. » Training is freely available online via Australian Mental Health Outcomes and Classification Network.

Screening tool name	Age range	Description
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 and 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

Preliminary Assessment

- Complete within 30 days upon entry to care.
- Assists to identify and immediate concerns.
- Builds rapport.

Comprehensive Health and Development Assessment

- Complete within 90 days of entering care.
- Complete annually.
- Must be completed in conjunction with screening for development and mental health.
- Provides in-depth examination and assessment.

Children's Health Queensland 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 MedicalDirector 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 action to be taken.	See instructions.
Are relevant team members aware of the availability of the templates?	☐ Yes: continue with activity. ☐ No: see action to be taken.	Communicate to the team the availability of the templates.
Have all team members completed the children in care training on DiscoverPHN?	☐ Yes: continue with activity. ☐ No: see action to be taken.	Refer to training module.
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 to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

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. 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.

Templates compatible with GP practice software are available from Brisbane South PHN.

Developmental assessments

If you have developmental concerns in children under six years, please refer to the pathway on SpotOnHealth HealthPathways.

Activity 2.3 – Checklist to review access to screening tools

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

Description	Status	Action to be taken
Do relevant team members have access to the National Guide lifecycle charts?	☐ Yes: continue with activity. ☐ No: see action 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 activity. ☐ No: see action 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 activity. ☐ No: see action to be taken.	Refer to screening tools. Please note: all the relevant screening tools can be accessed on the SpotOnHealth HealthPathways page. How will this information be made available to all team members?
Have all team members completed the children in care training on DiscoverPHN?	☐ Yes: continue with activity. ☐ No: see action to be taken.	Refer to training module.
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 to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

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 or My Health Record.

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.

Description	Status	Action to be taken
Are all GPs in your practice registered to use PRODA?	☐ Yes: continue with activity. ☐ No: see action 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 action 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 or My Health Record?	☐ Yes: continue with activity. ☐ No: see action 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 action 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 action 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 activity. ☐ No: see action 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 activity. ☐ No: see action to be taken.	See information on How to get an immunisation history statement.
Do you know the contact details of AIR?	☐ Yes: continue with activity. ☐ No: see action 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 to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

NIP and Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are at increased risk of serious diseases and can get extra vaccines for free through the National Immunisation Program. The National Immunisation Program schedule has recently been updated to include all eligible vaccines.

To identify Indigenous people who may require additional vaccines, vaccination providers can now record Indigenous status directly on the Australian Immunisation Register (AIR) and it will not be over-ridden by their status recorded by Medicare. AIR Indigenous status will not be recorded on any other government database and it does not need to be the same as Medicare.

Vaccination providers should seek consent from the person at the time of a vaccination encounter before recording their Indigenous status on the AIR. There is no change to how a person's Indigenous status is recorded on the AIR.

Recording an Indigenous status on the AIR helps vaccination providers to identify and give the clinically correct vaccination schedule.

Activity 2.5 – Reviewing immunisation schedule for Aboriginal and Torres Strait Islander patients

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

Description	Status	Action to be taken
Are relevant team members aware that there is a dedicated immunisation schedule for patients who identify as Aboriginal and Torres Strait Islander?	☐ Yes: continue with activity. ☐ No: see action to be taken.	Refer to the immunisaton schedule from NIP. How will this information be communicated to the practice team?
After reviewing your teams understanding of the immunisation schedule for Aboriginal and Torres Strait Islander patients, 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.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 3 – Integrated care

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.

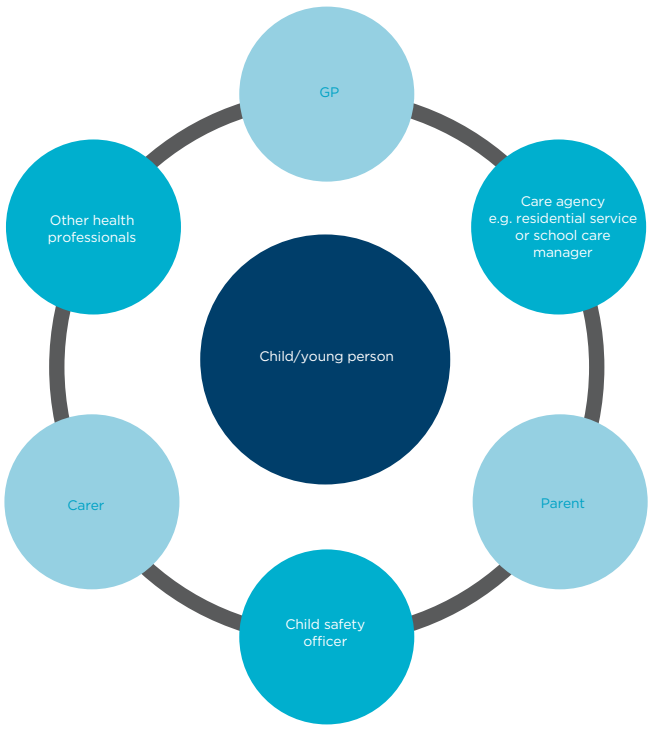
Activity	Nurse	GP	Practice Manager	Receptionist
Update guardian details including child safety service centre contact details.				
Updating allergies and reactions.				
Updating any relevant history including birth history, medical history, social, and family history.				
Reviewing immunisation history 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.				
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.				

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's 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 or GP (can be either) 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

It is recommended that all children and young people in care receive six monthly dental checks. This should commence from first tooth. These services are available from Metro South Health Oral Health Service.

Metro South Hospital and Health Service Oral Health Services

Publicly funded general, specialist, and emergency oral healthcare services for children, adolescents, and adults.

1. Check the criteria.
2. Contact the service:
   - Patients and/or caregivers can self-refer by phoning 1300 300 850.
   - See the website for more information about making an appointment.

Activity 4 – Children and young people in care and medicare

A range of MBS services provided by GPs are available for children and young people in care. There are NO specific item numbers for OOHC consultations, however, you may consider 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.

MBS items

Complete appropriate MBS item numbers:

- MBS item numbers available for children in care
- Health assessment
- Aboriginal and Torres Strait Islander health assessment (MBS item 715)
- GP management plan
- Team care arrangements
- GPMP/TCA review x 3 times per year
- Nurse chronic disease item number
- Mental health treatment plan

TIP: GPs are required to make sure each patient meets the MBS criteria prior to claiming each item number.

Please note: please be aware that patients may have out of pocket expenses for visits to allied health and mental health workers under TCA & MHTP. Consider who will cover this cost.

Chronic disease management plans 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.

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 isn't yet enrolled in Medicare, child safety can arrange this.
- 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 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: continue with activity. ☐ No: see action to be taken.	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 action to be taken.	Can GPs review their day sheet of billings? ☐ Yes ☐ No 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 action 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 action to be taken.	Email: askMBS@health.gov.au Provider Enquiry Line - 13 21 50.
Do relevant staff know that Medicare provide online training modules?	☐ Yes: continue with activity. ☐ No: see action to be taken.	More information can be obtained from Medicare Australia e-learning modules.
Have all team members completed the children in care training on DiscoverPHN?	☐ Yes: continue with activity. ☐ No: see action to be taken.	Refer to training module.
After reviewing the number of MBS items available for children 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 your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 5 – Referral pathways

SpotOnHealth HealthPathways

Refer to the Children and Young People in Care health pathways, on SpotOnHealth for full details of potential members of the multidisciplinary care team.

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 seven 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.

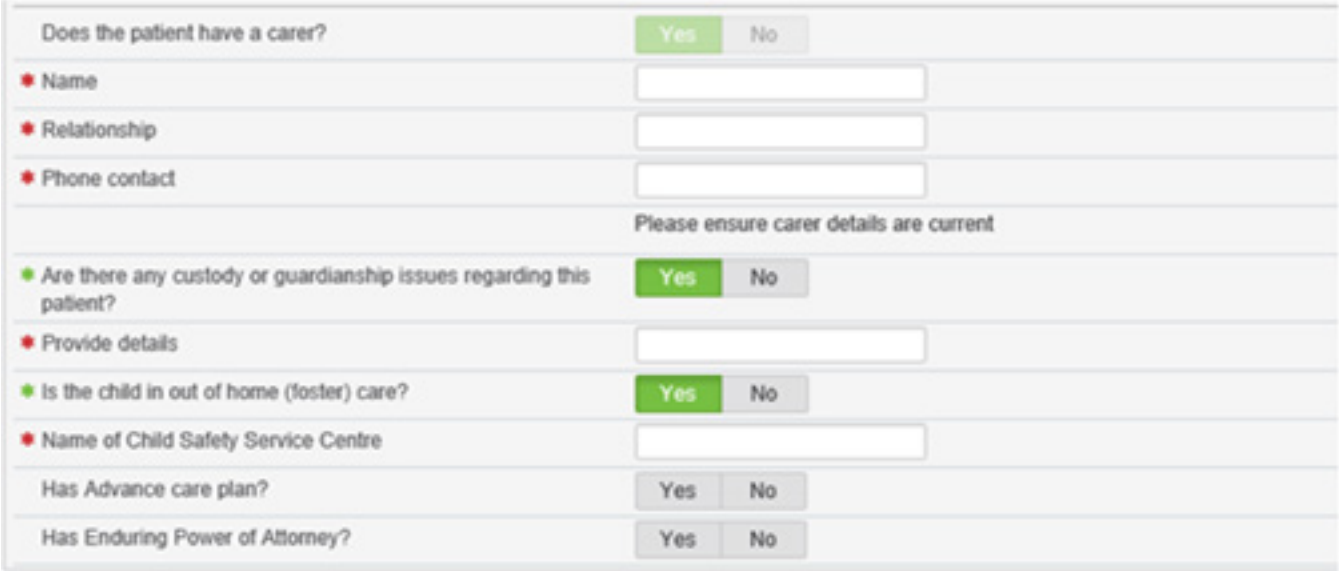
The CPG will help professionals decide whether to report to the Department of Child Safety, Youth and Women (Child Safety) or refer to other service providers, to help families receive appropriate support and services in a timely manner.

GP Smart Referral

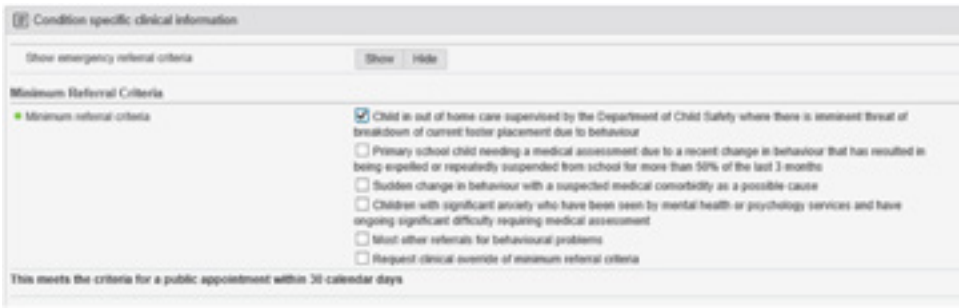
Smart Referrals are digital referrals integrated with Best Practice and MedicalDirector software to enable faster, streamlined management of referrals to Queensland public hospitals. Register here for Smart Referrals. A number of templates are available on the Brisbane South PHN website.

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 the 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 the Child Safety Service Centre

Clinical pathway selection search term
Behavioural problem in a child <6 years (General Paediatrics)

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

Patient contacts / Next of kin			
Name	Contact	Address	Relationship
Carer name (patients nominated contact)	Phone: Carer number (mobile contact)	Not provided	Carer relationship

Referral letter	
Field	Value
Carer name (patients nominated contact)	Phone: Carer number (mobile contact)

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.

Refer your patient

Metro South Health is the major provider of public health services, and health education and research, in the Brisbane south side, Logan, Redlands and Scenic Rim regions. The refer your patient website assists health professionals with accessing public health services for patients. It provides a single point of entry for all new referrals.

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 login details for SpotOnHealth HealthPathways?	☐ Yes: continue with activity. ☐ No: see action to be taken.	Register on the login page to request access.
Do all relevant team members know where to find more information about the NDIS?	☐ Yes: continue with 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 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 activity. ☐ No: see action to be taken.	Register here for Smart Referrals.
Do you know who to contact if you have any issues with Smart Referrals?	☐ Yes: continue with activity. ☐ No: see action to be taken.	The Metro South Health GP Liaison Officer (GPLO) Team are able to assist and support you through the Smart Referral process. Please call 1300 364 155 - Option 2 or email GPLO_Programs2@health.qld.gov.au.
Do all GPs know to include details about out-of-home care status on referral?	☐ Yes: continue with 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.
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 to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

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	☐	☐		
Transfer of patient care	☐	☐		
Patients' rights and responsibilities	☐	☐		
Mental Health first aid	☐	☐		

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 to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

Activity 7 – Recalls and reminders

As part of the RACGP accreditation standards, it is a requirement that practices provide health promotion, illness prevention, preventive care and a reminder system based on patient need and best available evidence. Brisbane South PHN have a recall and reminder QI toolkit to assist you and your practice to:

- differentiate between recalls and reminders
- understand the requirements of the RACGP Standards for General Practice 5th edition in relation to recalls and reminders
- describe the key components of a recall and reminder system
- understand the role of technology in streamlining contact with patients.

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 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 it 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. ☐ No: see action to be taken.	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
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.
Does the recall and reminder system take into consideration patients with low English proficiency?	☐ Yes: continue with activity. ☐ No: see action to be taken.	Revise or implement practice policy. Letters and voice phone messages can be confusing for patients with limited or no English. Using the Translating and Interpreting Service to call the patient or sending text messages can be more effective. Consider using the online Appointment Reminder Translation Tool.
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 to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

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 January 2022.

- National Clinical Assessment Framework for children and young people in out-of-home care.
- Out of Home Care toolbox.
- Brisbane South PHN - GP Psychiatry helpline.
- DiscoverPHN – Children in care training for general practice.
- Health translations.

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.
- Brisbane South PHN Aboriginal and Torres Strait Islander resources.
- 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.

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.

MBS item number 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.

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.

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 action 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 action 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 to help set your goals. ☐ No, you have completed this activity.	Complete the MFI template for your practice. Refer to the example MFI at the end of this document.

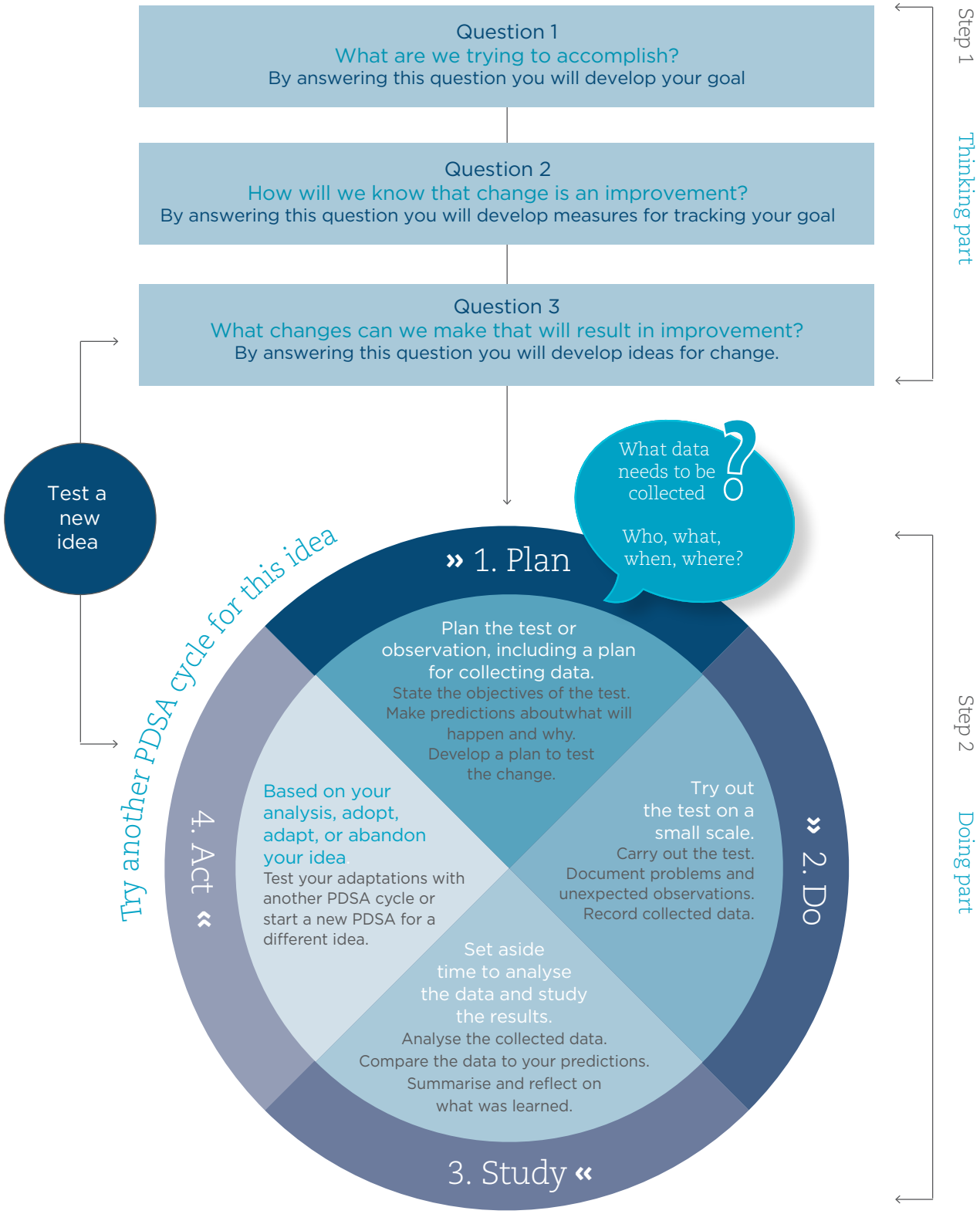
Links to other QI toolkits

Brisbane South PHN have a suite of QI toolkits available for general practice. After completing this toolkit, you may benefit from choosing one of the following:

- Mental health overview – this toolkit is designed to assist practices to review their patients who may be affected by a mental health condition. This is an introduction module for a number of mental health toolkits.
- Alcohol and other drugs – this toolkit is designed to identify patients, develop a register of patients to facilitate better continuity of care and better manage the physical health and co-morbidities of patients experiencing problematic substance use and/or dependency.
- Eating disorders – this toolkit can assist to identify patients with and at risk of an eating disorder, including screening and assessment of those with relevant co-morbidities or presentations. It also includes prevention, early identification, appropriate intervention including referral pathways and identifying eligible MBS eating disorder and other funding streams.

The full suite of toolkits are available on Brisbane South PHN's website. PDF fillable workbooks are available on DiscoverPHN.

Model for improvement diagram



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

MFI and PDSA template EXAMPLE

Step 1: The thinking part - the three fundamental questions

Practice name:	Date:
Team members:	
Q1. What are we trying to accomplish?	**(Goal)**
By answering this question, you will develop your GOAL for improvement. Record this as a S.M.A.R.T. goal (**S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**ime bound).	
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 more specific and has a time limit. So, for this example, a better goal statement would be: Increase the proportion of our children and young people in care, having a health assessment completed by 50% by 31 July.	
Q2. How will I know that a change is an improvement?	**(Measure)**
By answering this question, you will determine what you need to MEASURE in order to monitor the achievement of your goal. Include how you will collect your data (e.g. CAT4 reports, patient surveys etc). Record and track your baseline measurement to allow for later comparison.	
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. BASELINE MEASUREMENT: 37% of our patients currently in care have an annual health assessment. DATE:	
Q3. What changes could we make that will lead to an improvement?	**(List your IDEAS)**
By answering this question, you will generate a list of IDEAS for possible changes you could implement to assist with achieving your S.M.A.R.T. goal. You will test these ideas using part 2 of this template, the 'Plan, Do, Study, Act (PDSA)' cycle. Your team could use brainstorming or a driver diagram to develop this list of change ideas.	
IDEA: Update practice information sheet to include living arrangements and carer contact details. Ensure this information is included in the patient's records. IDEA: Identify children and young people who are currently living in care and review if they have had a health assessment completed. IDEA: Upload health assessment templates into practice clinical software package. IDEA: Ensure all relevant team members are aware of how to access health and development assessment templates and understand their role within the assessment.	

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 template to test an idea. Ensure you communicate the details of the plan to the entire practice team.

Idea	Record the change idea you are resting
Which idea are you going to test? (Refer to Q3, step 1 above)	
Identify children and young people who are currently living in care and review if they have had a health assessment completed.	
Plan	**Record the details of how you will test your change idea**
Plan the test, including a plan for collecting data	What exactly do you plan to do? Record who will do what; when they will do it (day, time etc) and for how long (1 week, 2 weeks etc); and where (if applicable); the data to be collected; and predictions about the outcome.
What: John will review the practice spreadsheet of the children at the practice who are currently in care. Each individual patient file will then be reviewed to see if there is a completed health and development assessment completed in the past 12 months. If an assessment has not been completed, John will contact the carer to see if an appointment can be organised. When John is checking the patient's file, he will also check to make sure there is an appointment reminder to ensure the patient is given a long appointment every time they visit the practice. Who/When/Where: Who: Nurse. When: Begin 20 May. Where: Dr Smith's office. Data to be collected: Number of active patients aged up to 18 years currently in care and the status of their health and development assessment. Predictions: 50% of children in care will have a health and development assessment completed in the past 12 months.	
Do	**Run the test, then record your actions, observations, and data**
Run the test on a small scale	What did you do? Were there any deviations from the original plan? Record exactly what you did, the data collected and any observations. Include any unexpected consequences (positive or negative).
Done – completed 20 May – the practice nurse reviewed the list of patient's who were currently living in care. It was identified that the practice was not recording this in care status in the correct fields of the practice software. This was rectified. John conducted an individual search on all the patients on the list to review the status of the health and development assessment. Children who had not had an assessment completed in the past 12 months were contacted via the carer. We identified that some contact details were out of date. John was successful in booking in some of the children and left a message on the other children's file to prompt them to have an assessment completed at their next appointment.	

Study	Analyse the data and your observations
Analyse the results and compare them to your predictions	Was the plan executed successfully? Did you encounter any problems or difficulties? What worked/didn't work? What did you learn on the way? Compare the data to your predictions. Summarise and reflect on what was learned.
At the end of the focus on completing health and development assessments on children in care, 44% of patients had an assessment recorded. This has resulted in a 7% increase in results however was 6% lower than our goal. Results have been shared with the whole practice team. The practice team was complimented for their efforts, even though we did not achieve our goal. Communicate the results of your activity with your whole team. Celebrate any achievements, big or small.	
Act	Record what you will do next
Based on what you learned from the test, record what your next actions will be	Will you adopt, adapt or abandon this change idea? Record the details of your option under the relevant heading below. ADOPT: record what you will do next to support making this change business as usual; ADAPT: record your changes and re-test with another PDSA cycle; or ABANDON: record which change idea you will test next and start a new PDSA.
Adopt: The practice has decided that this is something that they would like to continue to do. This is an important assessment, so the practice wants to continue to see improvements in this area. Adapt: Abandon:	

Repeat Step 2 to re-test your adapted plan or to test a new change idea

Acknowledgements

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The information in this toolkit does not constitute medical advice and Brisbane South PHN accept no responsibility for the way in which the information in this toolkit is interpreted or used.

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