



GENERAL PRACTICE

QUALITY IMPROVEMENT TOOLKIT

CHILDREN AND YOUNG PEOPLE IN CARE TOOLKIT

A practical guide to improve care coordination and management of children and young people in care as a CQI activity and for PIP QI and CPD purposes.

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Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and the traditional practices of the families of the Yugambeh Language Region of South East Queensland and their Elders past, present and emerging.

Artwork: Narelle Urquhart. Wiradjuri woman.

Artwork depicts a strong community, with good support for each other, day or night. One mob.

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CHILDREN AND YOUNG PEOPLE IN CARE TOOLKIT

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

GCPHN would like to acknowledge that much of the source material was originally created by Brisbane South Primary Health Network.



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ABOUT THE CHILDREN AND YOUNG PEOPLE IN CARE TOOLKIT

This Toolkit provides a practical guide for general practice teams. It describes how to successfully implement the care coordination and management of children and young people in care in a practice as a Continuous Quality Improvement (CQI) activity, and for Practice Incentives Program (PIP) Quality Improvement (QI) and Continuing Professional Development (CPD) purposes.

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. Care coordination and management of these patients is crucial.

- Children in care have poorer physical, developmental and mental health outcomes compared with their peers. Furthermore, people who have experienced trauma, or adverse childhood experiences (ACEs), have poorer health outcomes later in life
- General practices are crucial in the early detection of health problems and intervention
- Considerations need to be made around who provides consent for medical decisions

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 delay¹

THE LIKELIHOOD OF HEALTH RISKS WITH FOUR OR MORE ACEs



¹ Young People in Out-of-Home Care, Health Pathways Melbourne (2018)

HOW TO USE THE TOOLKIT

There are six steps to implement the CQI activity for children and young people in care.

STEP 1 Planning and preparation

STEP 2 Use data to set goals and identify suitable patients

STEP 3 Implement improvement actions

STEP 4 Regularly review your CQI activity

STEP 5 Sustain and maintain improvements

STEP 6 Document your CQI activity



AIM OF THE TOOLKIT

To provide a simple and practical guide for general practices to implement the care coordination and management of children and young people in care as a CQI activity.

The Toolkit supports general practice teams to:

- successfully implement care coordination and management of children and young people in care
- make best use of practice data
- document the CQI activity for children and young people in care
- use the CQI activity for PIP QI and CPD purposes
- make measurable and sustainable improvements in a feasible manner to patient care within the specific population group
- increase knowledge of CQI principles and practical application

BENEFITS OF USING THE TOOLKIT

The Toolkit provides:

- a structured, easy and quick approach to implement quality improvement activities
- a step by step guide
- suggestions to identify patient groups using data extraction tools
- links to prefilled templates and resources
- flexibility; activities can be started at any time of the year, and practice teams decide whether to implement a single improvement intervention, or a bundle of interventions
- This Toolkit is especially relevant to the Gold Coast context because it was developed by GCPHN staff, in consultation with Qld PHNs, Children's Health Qld, Gold Coast Health, primary care staff and Kalwun Health Service.

STEP 1 PLANNING AND PREPARATION

1.1 TEAM MEETINGS

- To meet [PIP QI requirements](#), you must demonstrate that you have undertaken your CQI activity as a team.
- It is important at the beginning of the CQI activity to arrange a practice meeting to agree, plan and prepare for its implementation. If it is not possible to have the whole team meet, each staff group should be represented. As a minimum, this would include a GP, the practice manager, a member of the administrative team and a practice nurse. In smaller practices, the same individual may have more than one role.
- You should continue to meet regularly to plan and review your CQI activities. It is especially important to meet at the conclusion of the activity and finalize the documentation.
- Meetings can be virtual or in person and can be scheduled at any time that suits the team, i.e. during or outside normal working hours.
- Practical considerations for your meetings:
 - You could add CQI as a standing agenda item on your usual team meetings; or you could set up specific meetings for this purpose.
 - Schedule meetings with advance notice to ensure key team members can attend
 - Examples of practice meetings and templates are available [online](#).
 - Ensure that you have access to CAT4, Primary Sense™ or other practice data during meetings to inform your discussions and to support your planning and review of your CQI activity.
 - Consider using a [CQI activity template](#) during meetings to help guide the discussion and to document your plan, progress and learning. There is also a [guide](#) to assist completing this.



TIP - Regular meetings help to maintain momentum and keeps the team on track to successfully complete the CQI activity.

1.2 AGREE CQI ROLES AND RESPONSIBILITIES

- It is important to define and delegate specific roles and responsibilities in the team. Potential roles or different team members are included as an Appendix.
- Consider in your team who has the skills and ability to complete each task. You could ask staff to gauge their confidence out of 10 to complete an allocated task- this can help identify learning needs.
- Ensure all team members have access to practice software 'How To' guides
- Identify and meet the training and education requirements of team members to fulfil their CQI role.
- Remember to share your CQI plan (template) with the whole practice team to ensure that everyone is aware of the activity and their roles and responsibilities.

1.3 SET REALISTIC TIMELINES

- It is important to specify the specific steps and estimate how long each one will take to complete. It is also important to agree dates in advance, when progress will be reviewed.
- Allow some flexibility with the timelines and expect and plan for delays.

STEP 2 USE DATA TO SET GOALS AND IDENTIFY SUITABLE PATIENTS

2.1 CURRENT PERFORMANCE AND FUTURE GOALS

- Ask the following questions to assess current and future performance using your practice data:
 - What is the current level of performance in the practice?
 - If there is an opportunity to improve performance? If so, by how much? Express your goal or target as a number or percentage.
 - Is your target realistic? It is seldom possible to achieve 100% performance; most practice teams can achieve a 25 to 50% improvement in performance or reduce the gap between their current and desired performance by 25 to 50% with concerted effort.
 - How long will it take to achieve this goal?
- A CQI activity is simply a structured, focused and co-ordinated attempt to close the quality gap between your current, baseline performance and a desired outcome or level of performance in the future.
- Practice teams that set SMART goals are more likely to be successful. The acronym SMART describes some of the desired characteristics of a goal: specific, measurable, achievable, relevant and timed.



SMART goal example

50% of patients at practice X identified to be in care will have a comprehensive health and development assessment using the out of home care templates annually and a health management plan shared with child safety and other care team members.

They agree that within the next 4 weeks they will 1) identify the patients that are known to be in care through a team meeting and 2) the practice manager will change the new patient form. They calculate that they have 10 patients and they set recalls and reminders for these health assessments to occur over the next 6 months. They will achieve their goal if 5 attend.

2.2 IDENTIFYING CHILDREN AND YOUNG PEOPLE IN CARE

- It is important to direct your improvement efforts at those patients who are most likely to benefit from them. The next step is therefore to identify children and young people in care who are practice patients.
- GPs and Practice Nurses may know which children attend the practice with foster carers or residential care providers.
- Best Practice users are able to conduct an *Out of home care conditions* search in past history or reason for visit. [See the CQI toolkit - Children and Young People in Care, How To Resource for practice software](#) for instructions.
- Communicate to the team those children in care who are a focus of the QI activity.
- Review new patient registration form to include care status and child safety details. This information is also needed for referrals to the hospital.

2.3 RECORDING CARE STATUS IN PATIENT RECORDS

- Record “Out of Home Care” status in the patient’s file in the diagnosis field (Best Practice), social history screen (Medical Director) as well as a warning, or on-screen comments.
- Record carer’s details and child safety details in patient details/family and social history screens.
- Best Practice users are able to enter in the diagnosis and reason for visit field as Out-of-home care.
- See the [CQI toolkit - Children and Young People in Care,How To Resource for practice software](#) for instructions.

Tip: 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** – knowing who has the authority to provide consent for the health and medical treatment of children and young people subject to child protection. 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 especially 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.



STEP 3 IMPLEMENT IMPROVEMENT ACTIONS

3.1. AGREE SPECIFIC IMPROVEMENT ACTIONS

- It is important to set a SMART goal and identify patients. It is equally important to decide what improvement actions or interventions will be required to reach your goal. In other words, what is it that needs to be done for every patient in your sample? Such as, an annual health assessment
- Decide whether your CQI activity requires a single intervention or multiple interventions
- Consider creating Top Bar prompts to automatically flag patients



TIP - A **care bundle** is a set or number of interventions that, when used together, synergistically improve patient outcomes.

TIP - Choose one distinct area to start e.g. Practice X will agree on a method to record children in care in the patient records and implement the system changes and staff training to enable this within 2 months.

3.2 EXAMPLES OF IMPROVEMENT ACTIONS IN A CQI ACTIVITY FOR CHILDREN AND YOUNG PEOPLE IN CARE

- Use data to identify patients with one or more missing or overdue items of care e.g. annual health assessment, mental health care plans/ reviews, immunisations, GP management plans
- Use your practice reminder system to 'flag' patients with missing or outstanding items of care. Whenever possible, reminders should also be added during patient appointments (See the [CQI toolkit - Children and Young People in Care, How To Resource for practice software](#) for instructions).
- GCPHN has developed a [prefilled CQI practical example](#)

Examples of potential improvement actions for identifying children and young people in care

- Review new patient registration forms to include tick box asking if child is in care and if so, obtain child safety details
- Ensure child's care status is recorded in the patient's file in a consistent agreed field (See the [CQI toolkit - Children and Young People in Care, How To Resource for practice software](#) for instructions).

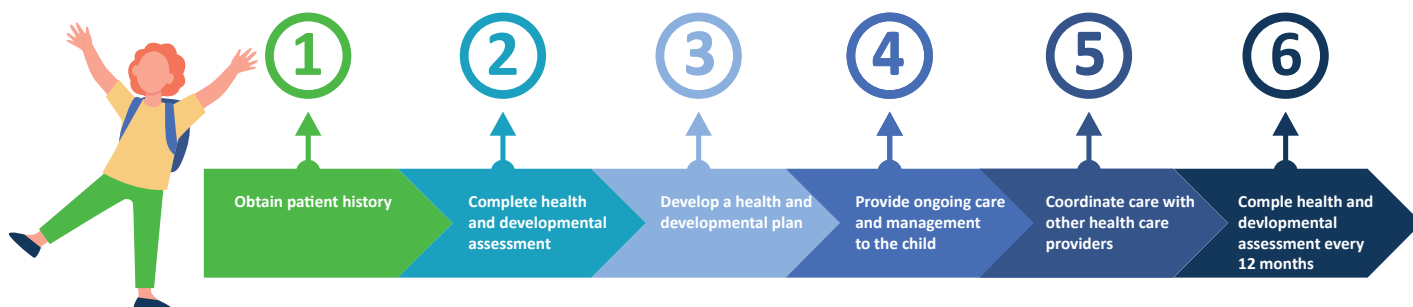
Examples of potential improvement actions for annual health assessments and health plans

- Ensure all children and young people in care have a comprehensive health and development assessment completed each year and a copy is given to child safety
- Ensure the practice has imported the Out-of-Home Care Health Assessment tools and has access to additional recommended screening tools (see the [Children and Young People in Care Patient Care Pathway](#))
- Review the 715 Aboriginal and Torres Strait Islander health check template in your software aligns to the [NACCHO RACGP National Guide to a Preventive Health Assessment for Aboriginal and Torres Strait Islander People](#) or use the [NACCHO RACGP template](#)
- Set recalls and reminders for annual health assessment – send to both carer and child safety

Examples of potential improvement actions for care coordination and management

- Encourage practice team members to be familiar with the [Children and Young People in Care Patient Care Pathway](#)
- Identify any staff within the practice with a special interest in children in care
- Set an appointment reminder in the patient's file to prompt booking a long appointment each visit (See the [CQI toolkit - Children and Young People in Care, How To Resource for practice software](#) for instructions).
- Review practice's systems to ensure patient has a comprehensive, up-to-date My Health Record
- Identify MBS funding that is available for children and young people in care
- Ensure trauma informed care is evident in practice policies and procedures

3.3 THE CHILDREN AND YOUNG PEOPLE IN CARE HEALTH ASSESSMENT PATHWAY: SUGGESTED ACTIVITIES



1. ASSESSMENT

- Prior to the assessment, check:
 - [Out of Home Care Health Assessment templates](#) are available in software
 - supporting information regarding child’s health and relevant family history
 - Medicare registration
 - My Health Record
 - details of any accompanying person
- Review guidance for performing assessment appropriately in the Children and Young People in Care Patient Care Pathway (e.g. legal and ethical issues, safe and trustworthy environment)
- Decide an appropriate assessment – preliminary health check and/or comprehensive health and developmental assessment



TIP - Complete a preliminary health check within 30 days of entering care. Complete a comprehensive health and developmental assessment within 3 months of entering care.

TIP - As well as their health status, it is important to consider a child’s developmental milestones and mental health. Screening tools are recommended in the [Children and Young People in Care Patient Care Pathway](#) for this.

Refer to [community child health nurses](#) for developmental checks.



3. REFER

- Consider the breadth of services that are available, wait times, costs and skills of practitioner. Consider all relevant parties including:
 - patient
 - child safety
 - carer
 - parent
 - child health nurse
 - child protection unit
 - care agency e.g. residential services or school care manager
 - other health professionals

2. MANAGEMENT

- Seek [specialist advice](#) as needed
- Develop a shared health plan
- hold case conference with child safety and other health team members
- Coordinate the care of the young person
- Set reminders to prompt booking of longer appointments
- Upload My Health Record Shared Health Summary
- If the person identifies as Aboriginal or Torres Strait Islander origin, link in with relevant services.

4. REVIEW

- Set recalls for 12 month review (or 6 monthly for < 5 year olds)
- Conduct the comprehensive health and developmental assessment and review the health management plan.



TIP - Children in care sometimes have Department of Child Safety funded services just for them. It's important to make the most of the right service at the right time by the right provider. Refer to the [health assessment pathway](#) for these.

Refer to the [Early Childhood Early Intervention NDIS partner](#) for any child under 7 with developmental delay

If determined that the child/young person has complex needs and a paediatric review is required, refer to the [Gold Coast Health Child Protection Unit](#) for a one-off review

It is recommended that all children and young people in care receive 6 monthly dental checks. This should commence from first tooth with [Gold Coast Health Oral Health Service](#)



Preliminary Assessment

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

Comprehensive Health & 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.



TIP - Provide a copy of the completed assessment and plan to child safety, carer and other health professionals.

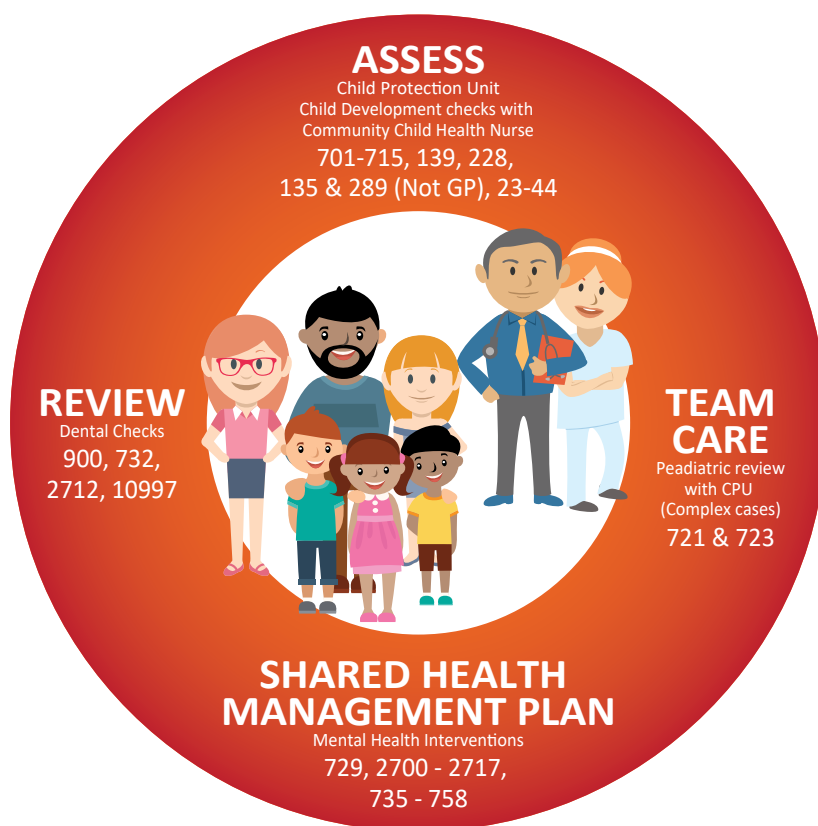
Children's Health Qld has [templates](#) available for preliminary and comprehensive health checks and assessments. These Out of Home Care templates are available in PDF and can also be uploaded as templates into Medical Director and Best Practice. For Aboriginal and Torres Strait Islander children in care, either an OoHC or [715 health assessment template](#) can be used. [NACCHO RACGP National Guide to a Preventive Health Assessment for Aboriginal and Torres Strait Islander People](#) is a practical resource with sections on children and young people and easy to use charts indicating the recommended screening by age.

3.4 TEAM BASED APPROACH TO CHILDREN AND YOUNG PEOPLE IN CARE

It is important to collaborate and work with other team members involved in caring for and managing children and young people in care. This includes the child safety officer, other health professionals, carer, parent and young person. 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.



3.5 MBS ITEMS TO SUPPORT IMPLEMENTATION

Complete appropriate MBS item numbers:

- [GP management plan](#)
- [Team care arrangements](#)
- [GPMP/TCA review x 3 times per year](#)
- [Nurse chronic disease item number](#)
- [Health assessment](#)
- [Aboriginal and Torres Strait Islander health assessment](#)
- [Mental health item numbers](#)



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

TIP: Refer to the [MBS flowchart](#) for children in care

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, the preference is for the practice to place billing on hold until Medicare options are fully pursued.

STEP 4 REGULARLY REVIEW YOUR CQI ACTIVITY

- It is important to monitor your progress regularly.
- During the planning and preparation step you would have identified the timelines and activity review points which should now be implemented

Practical considerations:

- Set the frequency of CQI progress reviews according to the timeline of your activity. For example, it would be reasonable to check the progress of a 12-week activity every fortnight.
- Use your practice data at each checkpoint (review) to determine your progress towards your goal. Remember to check that the data corresponds with the period being reviewed.
- Identify the barriers or challenges (if any) to your progress during the reviews. Consider whether and what corrective actions to take.
- The following questions may be helpful to work through during your CQI activity reviews:
 - o Successes- what has worked well so far?
 - o What were the challenges and barriers?
 - o Were you able to overcome the challenges and barriers? If not, what do you need to do next?
 - o If you were able to overcome challenges or barriers, what did you learn, and how can you use that in future?
- During the final review meeting, when you conclude your CQI activity, it is important to consider and document:
 - o What worked well?
 - o What could have worked better?
 - o What were your learning points, learning needs and were learning needs met?
 - o What changes did you make to your practice policies and procedures or systems because of this CQI activity (if any)?
 - o What CQI activity should we do next related to children and young people in care?

STEP 5 SUSTAIN AND MAINTAIN IMPROVEMENTS

- Once performance has been improved, it usually requires regular reviews to maintain the gains.
- It is therefore important to establish a reliable procedure to ensure your improved performance is sustained.
- New processes that are developed need to be documented and communicated to the wider team to ensure ongoing implementation is achieved.
- Agree the intervals at which you will review your performance relating to this activity, decide who will be responsible for the review, and the actions that will be taken if performance falls short of your new standard.
- Consider potential topics for a new CQI activity, and how your experience with this activity can help you to be more efficient and effective.
- Share your CQI activity, its successful outcomes and learning points with everyone in the practice team.



TIP: Speak with GCPHN if you would like support to showcase your work and share with your Gold Coast peers.

STEP 6 DOCUMENT YOUR CQI ACTIVITY

- Ensure you document your CQI activity to meet the PIP QI guidelines. Documentation is also a requirement for CPD purposes.
- Documentation must be kept for 6 years for evidence of PIP QI.
- It is especially important to document your baseline and improved performance, and list improvement actions and learning points.
- If your CQI activity has resulted in changes to your policies and procedures, they can be included in the documentation as attachments and evidence for accreditation purposes.
- There is no single 'right way' to document a CQI activity. The types of documents and templates we provide in this Toolkit are intended as examples. Practice teams can modify them to suit their own needs.
- There are three main types of documents that are required for a CQI activity. The fourth type of document is desirable but not essential. All documents are 'living' in the sense that they can be updated throughout the CQI process. The four types are:

- 1 Documents about meetings. A CQI activity requires at least two team meetings – one at the beginning and one at its conclusion. It is strongly recommended to also record your review meetings or 'check points'.
- 2 Documents about data. This type of documents could include reports from Pen CS or Primary Sense with aggregated performance data. It can also include lists of patient names that were sampled. These documents are not routinely shared and should be managed according to data privacy and governance procedures.
- 3 Documents about the CQI activity. GCPHN developed a CQI activity template that enables practice teams to document any CQI activity from beginning through to its conclusion. The template is suitable for PIP QI and CPD purposes. The template can be found [here](#)
- 4 Documents about practice policies and procedures. Practice policies and procedures- changes can be saved as evidence for PIP QI

ADDITIONAL SUPPORT AND INFORMATION

PIP QI

- For your children and young people in care CQI activity to be suitable for PIP QI purposes, you must ensure that all the requirements have been met.
 - See details of the PIP QI requirements on [GCPHN webpage](#)
- GCPHN can provide virtual/face to face meetings or access to recorded webinars that will provide:
 - worked examples of CQI action plans to support implementation and meet PIP QI requirements
 - tips to support CQI implementation

CPD

- If general practitioners would like to be eligible for CPD points for participating in the children in care CQI activity, further information can be found on [RACGP](#) and [ACRRM](#) webpages
- Local and national training and education on children and young people in care is available on the [GCPHN Education and Training page](#).

CHILDREN AND YOUNG PEOPLE IN CARE

GCPHN Senior Project Officer - Strengthening Health Pathways for Children in Care project can provide:

- resources and training options on child protection and health of children in care
- general practice peer support network and Community of Practice
- access to child safety care coordination support
- tips to support working with child safety
- specialist services for advice
- avenue for addressing barriers, gaps and opportunities to improve health outcomes and integration with child safety and the health system

A local [Health Assessment Pathway for Children and Young People in Care](#) has been developed in collaboration with Child Safety, Gold Coast Health and Hospital Service, general practices, Kalwun Health Service, allied health/private providers, Foster and Kinship Care Agencies, Department of Education and relevant community based services. It outlines each stakeholder's role and responsibilities for the health assessment of children in care.



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CHILDREN AND YOUNG PEOPLE IN CARE RESOURCES

- [Children and young people in care Patient Care Pathway](#)
- [Cycle of Care – team based approach to children and young people in care](#)
- [Information for Practice Nurses – Children in Care](#)
- [National Clinical Assessment Framework for children and young people in out-of-home care](#)
- [Out of Home Care toolbox](#)
- [RACGP guides on Aboriginal and Torres Strait Islander Health](#)
- [Training and education on working with children in care](#)

General Information on the Child Protection System

- [Department of Children, Youth Justice and Multicultural Affairs](#)
- [Medical Decision-Making Guide for Health Professionals](#)
- [Information Sharing Guidelines](#)
- [Family and child connect](#)
- [Queensland Child Protection Guide](#) - tool to assist professionals' 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

OTHER GCPHN CQI TOOLKITS

GCPHN has developed a range of toolkits which are available on the [GCPHN website](#).

APPENDIX

POTENTIAL CQI ROLES AND RESPONSIBILITIES OF PRACTICE TEAM MEMBERS

General Practitioners

- Provide clinical oversight and governance of the CQI activity
- Perform clinical review on each patient
- Respond to recall/reminder systems
- Check mental health status and offer support
- Assess eligibility for MBS items
- Review medications
- Arrange referrals to relevant team members
- Upload information to My health record

Practice Nurses

- Support the implementation of the CQI activity
- Provide support to generate data reports
- Identify patients to provide opportunistic interventions
- Update any relevant history including: birth history, medical history, social and family history
- Provide clinical support and assessments including recording preventative data measures such as height, weight, BMI, head circumference, immunisations, vision assessment
- Obtain any immunisation history from AIR and ensure this information is incorporated into the patient's file at the practice

Practice Manager

- Maintain up to date patient registers
- Analyse practice data
- Identify and support implementation of training for the CQI and practice team
- Establish and oversee recall/reminder systems ensuring all recall/reminders are sent to the patient, carer and child safety
- Monitor progress against CQI activity
- Review and update new systems to ensure sustainable change
- Document policy and procedures and support implementation across the team
- Provide copies of health assessments, referrals and any other relevant information to child safety following guidelines of GP

Reception Staff

- Order and maintain supplies of resources (eg patient information)
- Add flags or clinician reminders for patients in the activity
- Support the practice team to identify patients eligible for relevant reminders and contact patients either via letter, text message, phone call etc
- Ensure children and young people in care have a long appointment allocated at each visit
- Ensure patient documentation is scanned and uploaded into the patient's file at each visit
- Record care status in patient records
- Assist GP to arrange case conferences

Medical and Nursing students (if relevant)

- Consider tasks that medical or nursing students could implement during clinical placements to support your CQI activities



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