Optimising general practice to meet the needs of young people in residential care: piloting three models.

FINAL REPORT

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phn SOUTH EASTERN MELBOURNE
An Australian Government Initiative

We acknowledge the out of home care providers who contributed to this work (Wesley Mission, Mackillop Family Services, SalvoCare Eastern), and acknowledge and pay our respects to the young people living in the residential care homes which participated in this pilot work and their professional carers, from whom we learn.

Larter.

Larter is an Australian-owned consulting firm providing high quality consulting services to the health and community services sector. Our clients include governments, community health services, Primary Health Networks, community sector organisations and peak bodies. Established in 2008 by Peter Larter, a Melbourne-based health economist, the company specialises in needs assessments, population based planning, engaging stakeholders, designing and evaluating health programs, providing education and training for healthcare professionals and strategic planning for local health systems. Peter is backed by a skilled and experienced team who are passionate about quality primary health care.

Larter Consulting acknowledges the traditional owners and custodians of the lands on which we work.

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Executive summary and recommendations.

Young people in out-of-home care should have the same opportunities as other young people.

This pilot project has taken place in the context of reforms in both primary health care and the out of home care (OOHC) sector, designed to strengthen person-centred care, particularly for people living with complex and chronic health conditions and improve the health and wellbeing outcomes for vulnerable children and young people in Victoria.

In response to recommendations from a previous phase of work, *Optimising general practice to meet the needs of young people in residential care: a needs assessment* (2016), a new model of care was developed for piloting in three locations in south eastern Melbourne.

This model tested the system response required to address the following needs:

- improved service accessibility and responsiveness to the needs of OOHC youth
- strengthened residential staff commitment to brokering young people's access to health services
- improved youth engagement with health and health services
- improved data custodianship and integration across Child Protection, OOHC and care teams.

The approach selected for trial to address the system access barriers for youth was the establishment of a medical home relationship: every young person in residential care should have a 'medical home' to provide continuity of health care. Ideally, the medical home is a multidisciplinary health clinic which is child and adolescent friendly.

The key benefits of a medical home for vulnerable young people living in residential OOHC include:

- comprehensive, whole-person care, including continuity of care, clinical integration & ehealth technologies
- relational approach to care
- shared decision-making, self-management and empowerment
- sensitivity to vulnerability and risk factors
- accessibility
- team-based care
- local healthcare pathways
- accountability, and systematic continuous quality improvement
- opportunities for patient participation in service co-design.

The pilot trialled three different approaches to the medical home model to compare varying levels of flexibility in primary health delivery that could cater to the needs of the target group:

1. General practice as medical home (outreach to residential settings) - Dandenong
2. General practice as medical home (practice-based, existing preferred provider) - Elwood
3. headspace centre as medical home (outreach) – Frankston.

In each model:

- Residential youth were engaged and assigned a care coordinator/navigator
- Clinical secondary consultation for residential staff was provided
- A collaborative and integrated shared care approach for ongoing care was developed.

The design of the pilot models emerged from the prior needs assessment and were responsive to each residential house site's needs and circumstances.

The pilot period lasted 12 months and was evaluated by Larter Consulting. This report discusses implementation and insights and learnings, and makes a series of recommendations for: (i) working with vulnerability in primary care; (ii) for the medical home model; and (iii) for each of the three stakeholder groups (SEMPHN, DHHS and out of home care service providers).

Recommendations

The recommendations are reported in three sections:

1. A systems approach to optimising general practice for working with vulnerability
2. A mapping of the medical home model for the south eastern Melbourne catchment of residential care homes
3. Stakeholder recommendations for: a. SEMPHN; b. DHHS; and c. out of home care providers

1. A systems approach to optimising general practice for working with vulnerability

From a primary health care perspective, a systems framework can drive a whole-of-practice approach to understanding, supporting and working through vulnerability in a way that is person-centred and ensures a safe, welcoming and inclusive healthcare environment.

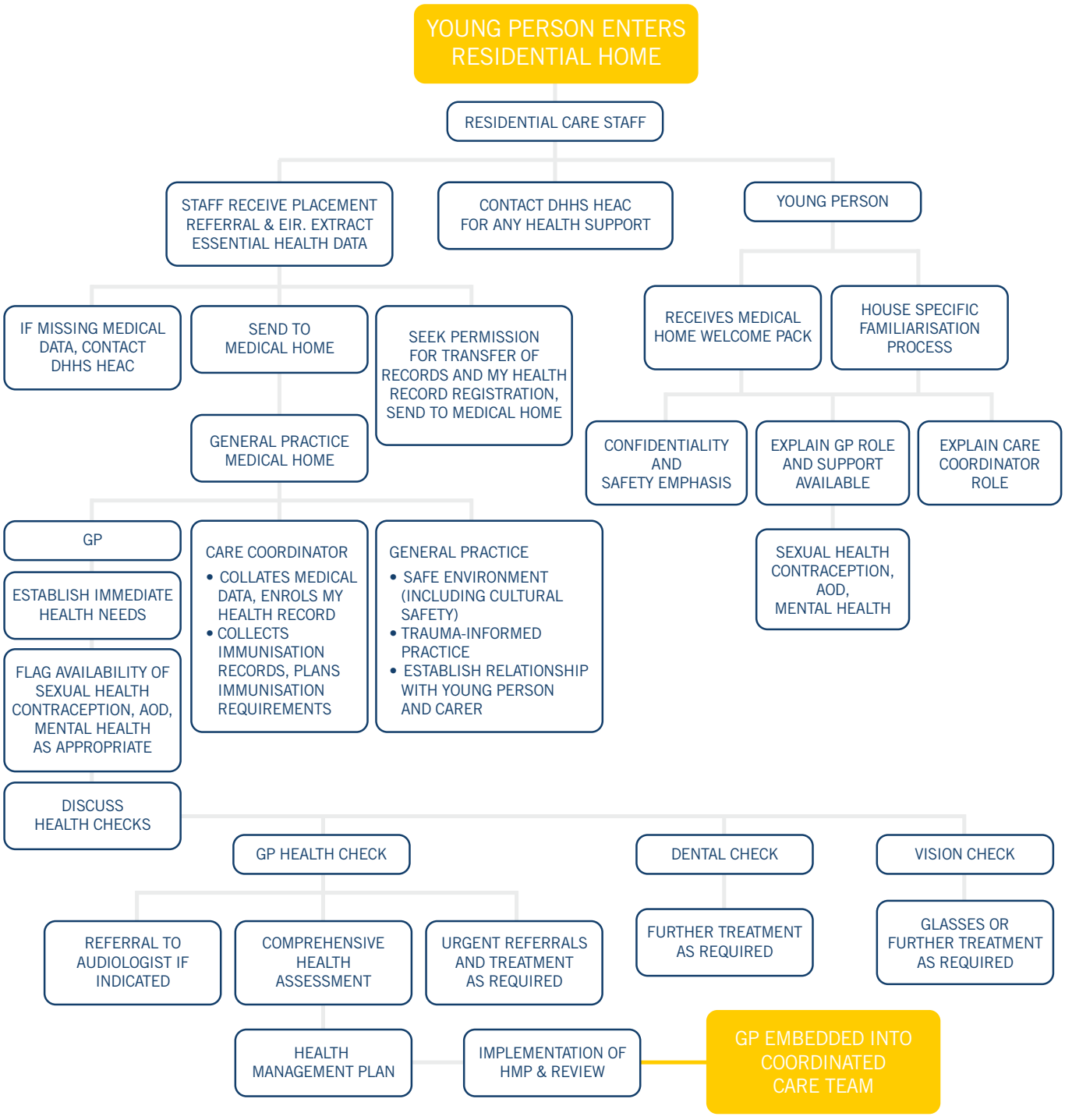
This project has identified the ten key building blocks depicted in Figure 1, that need to, as a minimum, underpin primary care approaches to working with vulnerable population groups, and should be used to guide next steps in building primary health care sector capacity.

Figure 1: Building blocks of a systems approach to working with vulnerability for primary care

2. A pathway of the medical home model for the south eastern Melbourne catchment of residential care homes

A pathway for the medical home model has been drafted that is youth-centred and wraps around the residential home to optimise access to primary care. The model builds in improving youth health literacy; establishing an OOHC-safe environment; building provider relationships; improved data transfer and communications. The model should be reviewed and revised by key stakeholders, and used as basis to guide next steps of commissioning and partnerships.

Figure 2: Medical home pathway for residential care in south eastern Melbourne



3. Stakeholder recommendations for:

3A SEMPHN

Scaling

- In partnership with DHHS, the pilot should be scaled to reach all the residential care houses across the south eastern Melbourne catchment (approximately 24 homes with some exceptions which may not be suitable for the model), supporting approximately 80 young people. A medical home may be matched to more than one residential care house by negotiation.
- The commissioning approach to the medical homes should include:
  a. Targeted selection of practices
     i. Existing (positively reported) relationship with GP or general practice
     ii. Close proximity/accessibility to house
     iii. Some proximity to a headspace centre for mental health support and literacy
     iv. Youth-friendly capacity
     v. Settings that minimise risk of stigmatisation for young people
  b. Co-design a framework, checklist and capacity building strategy for OOHC-sensitive and inclusive general practice (see recommendation 1)
  c. Quality improvement processes
  d. Some onsite engagement/home visits as necessary
  e. Development of relevant policies/standards/procedures/position statements
- Approach should be supported by
  a. Formalisation of medical home pathway model (recommendation 2) through process of co-design with DHHS, SEMPHN stakeholders
  b. Strong communication strategy
  c. Establishment of practice network across south east Melbourne medical homes
  d. Support from SEMPHN Practice Networks as needed
  e. Health Care Homes training for general practices on care coordination, leadership, etc where available

Medical home – participation requirements for general practice

- A summary of the approach and requirements is included in Appendix 4, including staff resourcing, systems requirements, capacity building and care coordination

Capacity building for General Practice

- Whole-of-practice capacity building: E-learning portal (located for example on SEMPHN Practice Coaching platform), with content for (i) reception & Practice Manager (ii) Practice Nurse, GPs. Includes links to existing resources and toolbox of local resources, comprised of fact sheets, tip sheets and guidelines (digital and/or hardcopy)
- Lunchtime training on trauma-informed practice for GPs working with young people in out of home care
- Networking, peer learning and collegial support through Vulnerable Youth Practice Network

Knowledge base and opportunities for alignment

Scaling medical homes for OOHC needs to be informed by:

- Evaluation learnings from: Pathway to Good Health; HealthPathways for GPs for OOHC (NWMPHN); South Initiative pilots; Ripple Project, Orygen
- Phase one Health Care Homes
- Doctors in Schools
- Policy context: Roadmap to Reform; A framework for vulnerability: Heath care that counts

Issues out of scope for this pilot project but identified as high priority for model

- Increased support for mental health
- Culturally informed models for supporting young Aboriginal people living in OOHC
- Support for residential care staff to facilitate brief smoking interventions
- Better understanding of after-hours primary health care use by young people
- Role of voice for young people with lived experience (i.e. CREATE Foundation), via consumer advisory bodies, headspace advisory bodies, in co-designing models, frameworks and resources

3B DHHS

The key to further development of this approach is a coordinated, committed and systematic response to build the capacity of the residential care workforce. Without investment in strategy and resource allocation, there will be no significant systematic and sustainable gains in health outcomes for these young people in the long term.

Scaling

- Every residential care house in Southern & Bayside Region should have a medical home relationship with a general practice
- Every young person entering care should be matched to a medical home. Information and resources about the medical home should comprise part of orientation to every house (for young people and staff)
- Communication strategy:
    a. Strong communications plan should be rolled out across Southern Region to all community service organisations and stakeholders supporting medical home approach
    b. Success for early adopters (pilot sites) should be shared, promoted, opportunities for mentoring explored
    c. A regionwide approach to health communication is needed
        i. Health forums; health eNews; co-design opportunities; (eventually leading to statewide portal for health in OOHC?);
        ii. support increased understanding of support available through Health and Education Assessment Coordinator

Workforce development

The residential care workforce needs an immediate injection of capacity around primary health care, and access to ongoing professional development. The residential care capability framework developed for the new Victorian Minimum Qualification Strategy for Residential Care Workers to come into effect in 2018 outlines the required capabilities in supporting safety, health and wellbeing, which require skills in cultural competence and ensuring cultural safety; promoting youth health and safety; supporting mental health; and responding to substance abuse. Investments made now in resources and training can be tailored to suit carers in other OOHC contexts.

Residential care staff need universal access to:

- Primary health orientation package (online), comprised on new and existing content
    a. Health in OOHC
        1. Understanding equity, inclusion & access
    b. Standards, policies and procedures
        i. Program requirements (health) for residential care in Victoria
        ii. National Clinical Assessment Framework for OOHC
    c. Medical Home 101 (familiarisation with the model)
    d. Primary care 101:
        i. Working with general practice
        ii. Medical data (My Health Record; collecting essential medical data)
        iii. Optimising access (confidentiality, mature minor)
    e. Issue-specific content
        i. Mental health, AOD, sexual health, nutrition
    f. Links and resources
        i. Local service pathways & resources
            a. SEMPHN stepped care
            b. Doctors in schools
        ii. Key digital resources for adolescent health
        iii. Key digital resources for working with vulnerable youth (OOHC toolbox)
- House handbook
    a. Mapped local services & pathways (e.g. a one-pager on local services: GP medical home, headspace medical home, dental, optometry, audiology, local sexual health service, tertiary mental health, free dental/eyes/hearing, allergy specialist, allied health, hygiene, sexual health/ sexualised behaviours)
- Health portfolio staff at each house:
    a. Ongoing professional development/support through a forum or discussion board or e-news (promoting new services, resources, training opportunities) (Child Protection workforce has access to regular professional development but this is not currently available to care staff)

Resources for young people living in OOHC

- House 'health hack' handbook
  a. Orientation to medical home
  b. Links to youth-friendly health promotion and advocacy, including for Aboriginal, LGBTI, people living with disability, CALD
     i. Health hacks on My Health Record, Health Care Concessions, Medicare, public health system
  c. Links to universal services & resources (e.g. CREATE Foundation, headspace, Frontyard, Melbourne Sexual Health Centre, Family Planning Victoria, VAHS, etc)
  d. Links to local services
     i. One-pager for every house: GP medical home, headspace medical home, local sexual health service, tertiary mental health, free dental/eyes/hearing, etc, allergy specialist, allied health
  e. Leaving care support

Data management

There needs to be a stronger and more consistent approach to data governance: more comprehensive and consistent recording, use and transfer of data which follows the young person and is transferred to the medical home in a timely and accurate way (including bundled transfer to new medical home if necessary). Resources and strategy need to be allocated to this change.

- Information needs to be systematically and accurately recorded on client files. Data transfer should be (securely) systematised wherever possible
- Information needs to have complete medical history (most recent health assessments, dental check, eye check, medications, allergies, immunisations)
- Information should be easily accessible, accurate and timely
- Stakeholders need to have equitable access to data
- Information should be provided to residential providers at point of referral and in turn should be transferred to medical home GP

Trial the Essential Information Record health data template in the medical homes.

Improved data governance is foundational to measuring meaningful outcomes.

A process for medical home transfer for young people transitioning between residential care houses in the region needs to be considered.

Continued focus on understanding and driving outcomes

Leadership, responsibility and accountability for outcomes must be shared across the Child Protection, Out of Home Care, contracted community service organisations and primary care sectors. This inter-sectoral collaboration needs to continue to explore how to measure meaningful outcomes from improved health care. This is best achieved in partnership with young people themselves. Young people's voices must be heard, valued and acted upon, and young people must play a key role in setting their own goals and the direction of their treatment and care plans.

Gains in reduced stress, resilience, improved mental wellbeing, help-seeking and system literacy and confidence offer a starting point.

Learnings from ongoing reform

Ongoing development of the medical home model needs to heed developments in the various South Initiative reform initiatives being tested, refined and evaluated in the local catchment until 30 June 2018. This includes the two new Intensive Support Service model homes established in Dandong and Noble Park.

Under the third direction of reform (Strengthening home-based care and improving outcomes for children and young people in out of home care), there are three areas of focus, with 10 activities being developed and tested that are designed to transform the way out-of-home care services are delivered at a local level, with a specific focus on: (i) improved client experience; (ii) improved outcomes focus; and (iii) improved governance and accountability.

Ongoing considerations

- DHHS Health and Education Assessment Coordinator resources/support should be more widely promoted
- Exploring how medical home model might support children and young people in other out of home care settings beyond residential care (foster care, kinship care, permanent care, lead tenant)
- An equitable approach to reducing smoking-related harms in vulnerable minors in state-funded residential environments

3C Out of home care providers

The scaling of the medical home model will not be feasible or sustainable without adequate leadership, commitment and resourcing from the community services providers in the residential OOHC care sector. This pilot phase demonstrated the difference in outcomes for sites with strong leadership and commitment to engagement and change.

The implementation of the medical home model requires training and systems support, including but not limited to:

- Demonstrated leadership and systems in place to support a medical home
- Policies and procedures that provide direction for understanding roles and responsibilities (practice guidelines, care pathways, relevant quality, data and safety systems)

This includes appropriate processes in place to enable continuous improvement of services.

Medical home – participation requirements for residential houses

- Engage portfolio staff (house team leader, one health leader/portfolio staff member)
- Delivery of *Introduction to OOHC* by care staff for medical home portfolio staff
- Meeting schedule for residential house and medical home general practice:
  a. Initiation & gap analysis workshop (lunchtime session)
  b. Informal site visits to residential house and to general practice
- House systems review
  a. Data custodianship (including but not limited to transferring Essential Information Record data to practice; supporting medical records transfer; My Health Record registration)
  b. Review agency approach to health assessments
- Communication and orientation strategy for medical home – for staff and young people
  a. Establish medical home familiarisation process and staff orientation process
- House care staff training
  a. Staff orientation package – online
  b. Quarterly learnings workshops with medical home Practice Nurse and team (during staff meetings)
- Depending on case management responsibility for agency, review options for greater GP role in care coordination

Context

This final report covers project activities between July 2016 and June 2017.

This pilot project has been conducted in the context of ongoing reform in the primary care system, designed to strengthen person-centred care and to deliver the right care at the right time in the right place, particularly for people living with complex and chronic health conditions. Recent reform includes ongoing quality improvement to care coordination; enhanced access to integrated primary mental health support (including a roll out of stepped care models); digital health reform through My Health Record; and the introduction of Health Care Homes that began in October 2017.[1]

At the same time, strategic policy developments aimed at improving the health, wellbeing, development and educational outcomes for vulnerable children and young people in Victoria have occurred. These include *Victoria's 10 year Mental Health Plan, Education State, Health 2040 and Back to Work*. Most importantly, the *Roadmap for Reform: strong families, safe children* maps reform for the out of home care (OOHC) sector in Victoria.[2]

The Roadmap sets a direction towards change in residential care — reconceptualising residential care as a transitional service with therapeutic emphasis to support young people's return to home-based care (parents, kinship, foster carers) or independent living.

The guiding principles underpinning these reforms include:

- Intervening early and providing the right assistance to reduce the risks of harm and costly interventions
- Improving the way services work together, provide continuity of care and integration around the individual needs of children, young people and families
- Building young people's personal capacity to make choices where appropriate and input to their care, guided by professional support
- Providing flexibility within and across service provision to scale up/down and adapt interventions to meet dynamic needs over time
- Building on localised services for people in their communities or place to deliver enduring outcomes
- Encouraging interaction with the people who use and deliver the system, leveraging strong local partnerships and joint strengths-based leadership across all communities and sectors.[3]

The Roadmap outlines three key directions for reform:

1. Building supportive and culturally strong communities
2. Supporting children, young people and families in need with integrated wraparound supports and targeted early interventions
3. Strengthening home-based care and improving outcomes for children and young people in out of home care.

Of key interest to this OOHC initiative is a strengthened state government focus on developing a learnings environment and outcomes framework for vulnerable young Victorians.

1 http://www.health.gov.au/internet/main/publishing.nsf/content/hea lth-care-homes

2 Roadmap for Reform: strong families, safe children: The first steps. DHHS 2016

3 Ibid.

The health care home for OOHC model

Residential care is an OOHC placement option providing temporary, short-term or long-term accommodation and support to children and young people who have been removed from the family home.

These young people have high and complex needs with serious emotional and behavioural problems caused by their exposure to trauma, including physical and sexual abuse, family violence and neglect.

This cohort of children and young people are among the most vulnerable young Victorians. They live with multiple behavioural, social and cognitive vulnerabilities that may be impacted by their lived experience of:

- significant neglect, physical and sexual abuse, subject/exposure to family violence, and anti-social family cultures
- complex mental health difficulties, including self-harming behaviours
- substance abuse behaviours
- reactive sexual behaviours
- criminal offending behaviours
- increased vulnerability to (re)exploitation and abuse.

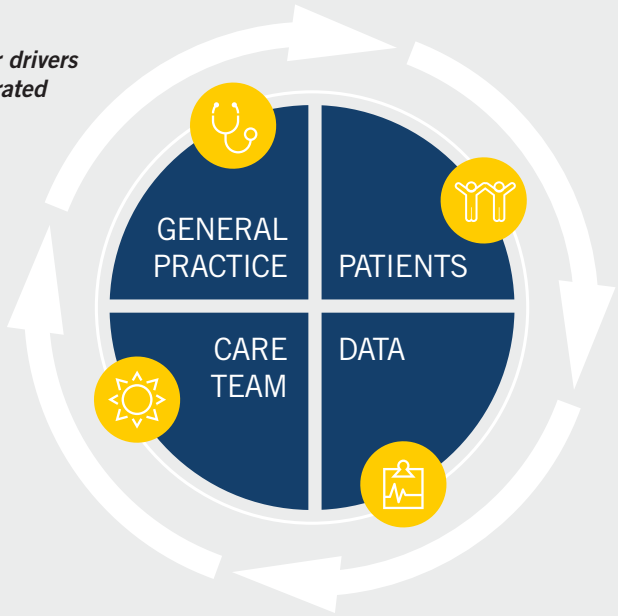
These complex needs intersect with barriers to service access and service responsiveness for all young people more generally.

The report of phase one of this work, *Optimising general practice to meet the needs of young people in residential care: a needs assessment* (2016) outlined their health and wellbeing needs and system response required to optimise access to primary health care for these young people and their professional carers. In summary, the key drivers of change required are:

- improved service accessibility and responsiveness to the needs of OOHC youth
- residential staff commitment to brokering young people's access to health services
- youth engagement with health and health services
- improved data custodianship and integration across Child Protection, OOHC and care teams.

Drivers for change need to come from both general practice and the residential settings in which these young people live.

Figure 3: The four drivers required for integrated change



The priorities for a service model to respond to these challenges included:

- innovative service and funding models to address the greatest barrier: youth engagement
- models of care with sufficient flexibility to cater for the varying and complex needs of this cohort
- familiarising primary health care providers with frameworks guiding OOHC health including relevant clinical guidelines
- building confidence and capacity of residential care staff to prioritise the completion of the Preliminary Health Checks; the Comprehensive Health and Developmental Assessments, through to the development of a Health Management Plan and ongoing assessment and monitoring processes for each young person in their care
- identifying youth friendly and residential care-friendly practitioners and practices in the south east Melbourne region to become preferred providers.

The primary health system response needs to be more flexible and patient-centred to better support these young people. General practice and other primary service providers need to develop capacity to become more OOHC-friendly and responsive to the needs of particularly vulnerable youth.

There needs to be an increased focus on improving the young patient experience in order to be able to aim for improved health and wellbeing outcomes. While for the general population, enhancing the patient experience includes improving quality, access and reliability, there are additional elements which need to be understood and optimised in order to better support people (and especially young people) living with vulnerability. The priority for these young people is creating service and care environments which are safe and welcoming, which provide consistency, stability and a sense of security, in order to successfully engage them towards overcoming attachment/trust issues with adults and institutional anxieties.

The approach selected for trial to address the system access barriers for youth was the establishment of a medical home relationship: every young person in residential care should have a 'medical home' to provide continuity of health care. Ideally, the medical home is a multidisciplinary health clinic which is child and adolescent friendly.

A **person-centred medical home** is a general practice selected to be responsible for a patient's ongoing, comprehensive, whole-person medical care.

In a medical home, patients have a continuing relationship with a particular GP, with this partnership supported by a practice team, and other clinical services in the local medical community wrap around the patient and families/carers as required.

The medical home coordinates the care delivered by all members of a person's health care team, which ensures that each person experiences integrated health care.[4]

The key benefits of a medical home for vulnerable young people living in residential OOHC include:

- comprehensive, whole-person care, including continuity of care, clinical integration & ehealth technologies
- relational approach to care
- shared decision-making, self-management and empowerment
- sensitivity to vulnerability and risk factors
- accessibility
- team-based care
- local healthcare pathways
- accountability, and systematic continuous quality improvement
- opportunities for patient participation in service co-design.

4 http://medicalhome.org.au/what-is-a-medical-home/

Objectives and approaches of the pilot model.

The overall objectives of the 12-month pilot program was to improve access to primary health care for young people in residential care and to build primary health care sector capacity to address the health needs of this marginalised group.

The pilot program employed three different approaches to the medical home model to compare varying levels of flexibility in primary health delivery that could cater to the needs of the target group:

1. General practice as medical home (outreach to residential settings) - Dandenong
2. General practice as medical home (practice-based, existing preferred provider) - Elwood
3. Headspace centre as medical home (outreach) – Frankston.

In each model:

- Residential youth were engaged and assigned a care coordinator/navigator
- Clinical secondary consultation for residential staff was provided
- A collaborative and integrated shared care approach for ongoing care was developed.

The design of the pilot models emerged from the phase 1 needs assessment and were responsive to each residential house site's needs and circumstances.

Methodology and actions.

For the 12-month pilot, SEMPHN contracted each of the three primary care medical homes to provide services to the cohort and liaise with residential providers. Project support was provided by Larter Consulting.

The service delivery model took a staged approach to building the medical home relationship, comprising:

- Residential onsite youth engagement activities (engaging young people and supporting residential staff)(models 1 and 3)
- Youth engagement with medical home general practice/ GP
- Workforce capacity building (general practice and residential care staff)
- Ongoing secondary consultation between residential care staff and a medical home GP (case conferencing, care planning, secondary consultation and continuity of care).

Further detail about each of the three pilot site models is discussed in the three local models on page 18.

The following sections summarise the key phases of project implementation:

- initiation and pilot site engagement
- pilot implementation.

1. Initiation and pilot site engagement

a. Sector engagement: CPD event for general practice

An introductory information and training event was hosted by SEMPHN in August 2016 to engage and inform interested general practice stakeholders and ascertain interest in being involved as a pilot site activity, and in the establishment of an Adolescent Health GP Network in south eastern Melbourne.

Training was also provided on building relationships with youth, working with youth, an introduction to OOHC primary care management, and conducting relevant health assessments.

The training was allocated 4 category 2 RACGP CPD points and delivered by

- Associate Professor Lena Sanci, Deputy Head of Department, Director of Teaching and Learning, co-lead of the Children and Young People's Research Stream, Department of General Practice, University of Melbourne, and
- Renee Hayden, Credentialed Mental Health Nurse, Family Therapist and educator for Larter Consulting, who has extensive experience implementing youth specific programs in general practice, and providing general practice training.

Session topics included:

- Best ways to construct the consultation, including an adolescent health assessment
- Barriers to youth health access
- What is a youth friendly practice?
- Medico-legal issues related to young people
- How to engage a disengaged young person
- Dealing with tricky situations
- Medication and young people
- Special needs - OOHC young people.

The event was simulcast via teleconferencing from Heatherton to sites in Frankston (headspace Frankston) and Berwick (Berwick Healthcare).

Sixteen participants attended, comprising a mix of GPs (including one International Medical Graduate), general practice managers, various headspace staff and residential care agency staff. Overall engagement was unexpectedly low, with feedback suggesting that there is sector-wide disengagement from youth health service provision.

b. Pilot site engagement

The recruitment and appointment of three general practices (or equivalent i.e. a headspace centre) to pilot innovative models of care took several months. Larter Consulting employed a focused mixed-methods approach to recruitment, including targeted direct invitations to:

- General practices identified as regular local service providers by residential units
- General practices with geographical proximity to the three sites selected (Dandenong, Frankston, Elwood)
- General practices that self-advertise as youth-friendly and/or with adolescent expertise.

The key learnings about recruitment from this phase were:

- To target practices that:
  a. have experience working with vulnerable populations
  b. have the willingness and capacity to involve whole-of-practice environment (team, process, policy, data)
  c. have the willingness and capacity to be flexible in prioritising patients, undertaking home visits, and ensuring service accessibility (such as through bulk billing)
  d. are relatively large, because larger practices seem to be able to be more flexible in their approach
  e. are relatively new and seeking to grow market share
  f. have a proactive practice manager who is progressive in their thinking
- To acknowledge and manage practice concerns, which included:
  a. a reluctance to take on additional initiatives during a time of significant reform and change
  b. apprehension about the safety of practice staff, and medico-legal risks
  c. lacking an appropriately skilled practice team
- To emphasise key enablers for engagement, which included:
  a. emphasising that there is a small patient load in a residential house (two or four patients)
  b. the initiative offers opportunities to improve health outcomes for vulnerable youth, and to build stronger connections with the local community
  c. Contracts and work plans

SEMPHN contracted with each of the three general practice service providers. The model and work plan for each site was separately co-designed with each medical home, tailored to a site's specific needs and circumstances.

2. Pilot implementation

a. Medical home initiation

Meetings were held at each of the three sites, bringing together key staff involved from both the general practice and residential house. For example in Frankston, 22 staff from all four SalvoCare Eastern houses met at headspace Frankston and received an introduction to the headspace model and its services from the Senior Project Manager/Youth Health Clinic Nurse and practice manager. In Elwood, the permanent staff team from Mackillop met at the MedicalOne clinic with GPs, nurses, Nurse Educator, management and other staff (15 people) to discuss context, issues and engage in interactive discussion. A lead staff member from Avoca House delivered a presentation on communication skills for working with young people in residential care.

b. Pilot resource pack

Each site received a welcome pack specific to each model, comprising the following fact sheets:

- Description of the site-specific primary care model
- Health and young people in Victorian OOHC
- Health program requirements for services providing residential care in Victoria
- National Clinical Assessment Framework for OOHC
- MBS for children and young people in OOHC
- OOHC Health Assessments software template (Best Practice or Zedmed)
- Sample cover letter to the GP or primary healthcare practitioner
- PACE principles for trauma-informed care

c. Workforce capacity building

We knew from phase one of this project (the consultation phase) that primary health care industry clinicians and staff are unfamiliar with frameworks guiding OOHC health care including the relevant clinical guidelines. We also knew that residential care staff need to build their confidence and to prioritise completing the Preliminary Health Checks; the Comprehensive Health and Developmental Assessments; the Health Management Plan and then to provide ongoing assessment and monitoring for each young person in their care.

The main capacity building activities for general practice teams were:

- CPD event on working with youth in general practice
- Lunchtime practice-based briefing sessions
- Monthly practice-based reflection sessions
- Practice support visits

For residential care staff, confidence and capacity building activities included:

- Staff meetings and discussions
- Team reflection sessions
- Staff training needs assessment
- Delivery of capacity-building interventions at team meetings

Further information about the outcomes of these activities are discussed in our learnings further in the report.

During initial project planning, the development and delivery of 8 hour GP Category 1 Mental Health Skills Training Activity tailored for OOHC contexts was considered. However, it was realised that there was insufficient demand from the sector for this training beyond the pilot sites, so this activity was postponed for this phase.

d. Project support activities

Project support activities varied by site and by the stage of pilot implementation.

The main support requirements of the two general practices were: (i) building the confidence and capacity of GP teams to be youth-friendly and residential care-friendly (ii) building familiarity with OOHC clinical guidelines (iii) designing models of care that have sufficient flexibility to cater for the varying and complex needs of young people in OOHC (including bulk-billing, flexible and prioritised appointment times, longer appointments, flagging young people in OOHC in data systems, having processes for health screening/assessment reminders, ensuring residential house liaison, managing case records, shared care, and the transfer of records).

Support in Dandenong focused on ensuring the GP was confident and able to undertake outreach engagement activities and home visits; undertake health assessments; and embedding a whole-of-practice approach (where the whole practice was familiar with the medical home model and the patient cohort).

Support at the Frankston and Elwood sites concentrated on facilitating discussion and agreement on the best model for their site. Opportunities for a youth clinic medical home embedded within a mental health service framework were discussed. They also explored efficiencies that could be realised by a practice delivering care across four different residential sites. Roles for general practice nurses in clinical models were also discussed.

Support for the residential units included developing communications mechanisms with medical homes; developing and disseminating fact sheets and tip sheets (for example on health assessments, the My Health Record system and HEADDSS), and working with staff on data collection and the secure transfer of medical records.

As a result of this work, stakeholders identified the need to develop various resources that could form a “general practice toolbox” for working with young people in OOHC, and a separate “residential care toolbox” for working with general practice. Draft tables of contents for both toolboxes were developed.

e. Evaluation

Throughout the pilot implementation, the project support worker from Larter Consulting collected qualitative data for participatory monitoring and evaluation during monthly GP/ general practice nurse/practice manager reflection sessions that had a set discussion guide; other general practice meetings; residential care staff workshops and meetings; and during ad hoc communications with site project managers.

Further information about the evaluation methodology and framework is below.

f. Learnings exchange and reflection

A number of events throughout the implementation year enabled action-based learning for SEMPHN. This helped ensure that adjustments could be made as learnings were identified. The events were:

- Regular meetings between SEMPHN, DHHS and Larter Consulting throughout the year
- Initial data collection/ethics meeting with SEMPHN, DHHS South Health and Education Assessment Coordinator (HEAC), DHHS Central Centre for Human Services Research and Evaluation, DHHS Central Out of Home Care Unit, Statutory and Forensic Services to discuss Departmental requirements for ethics approval for young people participating in pilot project and explore any opportunities to collaborate on data collection
- A midpoint workshop with DHHS Southern HEAC and Child Protection, and DHHS Central to discuss data governance across child protection and OOHC data collections
- A learnings workshop bringing together medical home and residential care stakeholders from each of three pilot sites
- A conference presentation at the National Primary Health Care Conference 2016 – "Improving primary care access in youth residential care: a 'medical home' model?" (See Appendix 1).

The three models are described in more detail over coming pages.

Model 1: General practice as medical home (outreach) - Dandenong

Medical home: Eastern Medical Centre

Residential care house: Jesson House, Wesley Mission Victoria, 4 young residents, therapeutic care model, RP3 complex care

Key medical home roles

- Youth health engagement and mentoring – general practice registrar

  The GP delivered outreach care navigation and youth engagement to the residential house. Initially this was provided weekly for one hour (for 4 weeks) and reduced to fortnightly for a few more weeks. Once young people were engaged and willing to visit the general practice clinic, the house visits reduced to as-needed, for clinical home visit appointments.
- Clinical support provider – general practice registrar

  One general practitioner was the portfolio holder for medical home services. They were involved in a care coordination role, to support young people to access the range of services needed to treat their complex needs
- Staff health liaison – general practice registrar

  The general practitioner provided secondary consultation and contributed to care coordination/shared care consultation with the residential care staff during fortnightly team meetings.
- Practice systems coordinator – practice manager

  The Medical Home prioritised young people's appointments and coordinated case records and shared care arrangements.

1. Youth health engagement and mentoring

This outreach role provided by the registrar had both youth engagement and system navigation responsibilities. This role required a person who is able to build the trust of young people, break down the barriers young people raise about accessing services, and sensitively discuss youth health issues such as contraception, sexual health, mental health or substance use.

The model began with onsite relationship-building and mentoring, and moved toward the integration of the model into practice including booking appointments, having a youth-friendly waiting room, and building prioritisation processes. An early goal was to ensure the Preliminary Health Check and Comprehensive Health and Developmental Assessments were completed for each young person.

The next phase continued to build a mentoring relationship to ensure the young person is attending the medical home and moving towards the development of a Health Management Plan and participating in ongoing assessment and monitoring, and attending to acute medical needs as required.

2. Staff health liaison role

Similar to the role of other liaison services available to residential care services (such as police liaison), this clinical role (GP in one site; Senior Youth Worker in another) formed an important component of the residential team. The role supported staff in their response to health issues and built capacity to better support young people to access primary health care. Opportunities for secondary consultation built the residential care team's capacity to better understand some of the complex health needs of the young people in their care, and to better assess and prioritise issues. Some of the issues identified included high-risk behaviours such as substance misuse and unsafe sexual practices. The availability of onsite secondary consultations is particularly important for residents that usually refuse to attend medical care.

The key goal was to ensure that all members of the residential care team focus on any recommended assessments, interventions or treatments as a priority in their work. This requires that residential care staff have the confidence and capacity to complete the Preliminary Health Checks; the Comprehensive Health and Developmental Assessments, Health Management Plans and ongoing assessment and monitoring processes for each young person in their care.

What worked well in this model?

- Onsite engagement efforts facilitated relationship-building and trust with young people and carer staff. After a few onsite visits by the GP, young people were engaged and choosing to attend the general practice and to complete the OOHC health assessments. This led to the completion of all comprehensive health assessments within six weeks
- Building a relationship of trust between the GP and individual young people achieved some health-related outcomes that residential care staff had not been able to achieve. For example, the GP collected pathology samples for testing from a young person that had been refusing to engage in their health care for several months
- GP attendance at residential house staff meetings built relationships with the staff who support young people to access care. While staff meeting attendance was not consistent throughout the 12-month period in Dandenong, staff stated they felt more engaged and the model worked better when the GP was able to attend. For example, staff reported the importance of secondary consult from the GP at a staff meeting to problem-solve support for a young girl with generational lice who is treatment-resistant
- Use of general practice registrars. The nominated practitioner for Eastern Medical Centre was the rotating registrar position, a position that changes every six months through new GP registrar placements. Key benefits of using registrars included
  a. the youth-friendly appeal of younger medical practitioner
  b. greater willingness to undertake home visits and after-hours appointments;
  c. having small or no existing patient load, increasing their ability to be flexible and provide timely, prioritised appointments
  d. being able to assess under pilot conditions the value of the relationship with a specific GP against the value of a dedicated role, with different individuals in that role. (The latter was valued more highly).
  e. project workers being able to test the use of both male and female GPs for a house predominantly comprised of young women at risk of sexual exploitation (discussed in further detail later in this report)
- The willingness of some GPs to undertake home visits after hours
- The therapeutic care (TC) model of Jesson House. The focus of this model is to support residents' feelings of safety and develop skills in distress tolerance, emotional regulation, the capacity to trust, and integration within the community. This can lead to greater trusting of adults and professionals, understanding of the importance of self-care, and greater appreciation of consequences and outcomes.[5] Young people in this setting were more engaged with the medical home and with accessing primary health care services than the other two pilot sites with no TC setting.

What remains challenging about this model?

- GPs need capacity building and specialist support to work in a house that accommodates young people at risk of sexual exploitation
- The medical home relationship needs to mature from one (portfolio holding) GP to a larger team of GPs to enhance flexibility and embed a whole-of-practice approach. The practice has recently added a second permanent GP to the medical home team
- GP attendance at residential house staff meetings needs to be regular and systematic
- GPs reported that access to more mental health support outside of the therapeutic care environment is required, including the development of new care pathways

5 Therapeutic Residential Care is a Victorian model with a holistic, structured therapeutic approach. A key differentiating feature includes a part time therapeutic specialist linked to each house, to guide staff interactions with young people, conduct assessments, develop therapeutic treatment plans and lead practice. Residential care staff receive training in trauma-informed care and access to ongoing training in areas such as child development, brain development and the effects of trauma, and therapeutic crisis intervention

Model 2: General practice as medical home (centre-based, existing preferred provider) - Elwood

Medical home: MedicalOne Elwood, team of five portfolio practice staff (2-3 GPs, 2 Practice Nurses, Practice Manager)

Residential care house: Avoca House, Mackillop Family Services, 4 young residents, RP3 complex care

Key roles

- Youth priority engagement: general practice nurses
- Clinical care: Team of portfolio holders: general practitioners
- Systems review: practice manager

This practice was the existing primary care provider for the residential house due to its close proximity and because it was already well known to the house staff and residents. However, there were no formal or informal arrangements in place to facilitate priority access for residents or to ensure continuity of care. The objective of the model was to improve and formalise the relationship.

The practice manager and practice nurses built relationships of trust with young people and care staff and supported resident's access to care. The practice uses a patient prioritisation system for case identification and to flag special arrangements for these patients (bulk-billing, prioritised appointments, special appointment times, longer appointments, health screening/assessment reminders, residential house liaison, case records, and shared care arrangements).

The general practitioners self-selected to be preferred providers/portfolio holders. Avoca House residents also identified their preferred providers, who were encouraged to participate. Doctors' training needs were identified regarding working with young people with complex needs and working within OOHC care frameworks.

At the practice, a group of staff were identified and sensitised to the OOHC context and to the Avoca House setting. At the house, the staff considered ways their site and agency's processes could support the medical home model.

What worked well in this model?

- A multidisciplinary care approach, including pharmacy, pathology, dentistry, physiotherapy, psychology, podiatry
- The practice offers multiple patient access options such as appointment booking and registration through website, telephone app and clinic kiosk
- The practice is corporatized, which offered benefits such as streamlined systems, having a large GP workforce so that the portfolio could be spread among a number of doctors, and the ability to invest in changes to improve efficiency (for example software changes, patient flagging systems, and having a mobile nurse educator)
- The practice nurses had an 'open door' policy for patients
- Residential care staff adopted familiarisation techniques during orientation. They included the general practice in a walking neighbourhood tour and offered initiation for the practice doctors and nurses
- Some GPs had experience working with OOHC youth in other practices
- The close proximity of the practice to the residential house enhanced youth access
- Good service access: seven days a week including public holidays
- There was continuity with an after hours GP provider (the National Home Doctor Service) and data sharing arrangements
- Good outcomes in catch-up immunisations with practice nurse support

What remains challenging about this model?

- The complexity of the resident cohort presented challenges such as high rates of absconding and service disengagement
- Some young people preferred to access GPs after hours, meaning that other practices were sometimes involved and there was no systematic approach to data sharing and transfer between clinics
- Practice-house staff relationships need to be further strengthened and ways found to embed staff liaison and support services
- There were inconsistent bulk billing practices
- The high casual staff workforce at residential house negatively impacted care continuity and the medical home relationship

Model 3: headspace centre as medical home (outreach) - Frankston

Medical home: headspace Frankston (hsF) Youth Clinic

The key headspace staff roles:

- Project Manager – project role
- Senior Youth Worker - youth engagement
- Two portfolio GPs – clinical support provider
- Practice Manager - systems support
- . Intake/Clinical Coordinator – pathways support

Residential care house: Four SalvoCare Eastern units (12 young people total): Melanda (2 young people), Sycamore (2 young people), Tower Hill (4 young people), and Bayside (4 young people), supported by three team leaders and one Manager of Residential Youth Services.

A health model wrapped around a headspace centre offers opportunities for multidisciplinary approaches, which has been identified by researchers as preferred practice when assessing health needs in OOHC settings (Webster 2016). The general practice Youth Clinic is one of many services available at headspace Frankston - hsF also has mental health services (including an early psychosis service), sexual health services and specific support for Koori people, LGBTI people and for neurodiversity. There are also youth programs and activities (such as martial arts), social groups, and opportunities for participation through youth reference groups. headspace Frankston is co-located with other youth services including drug and alcohol support, community mental health, housing, employment, and other services. There is a focus on building and maintaining supported referral pathways.

Key activities:

- An initial project meeting was hosted by headspace Frankston with 22 SalvoCare Eastern residential care staff from all four houses attending
- The headspace Senior Youth Worker spent 12 weeks developing a business framework and ensuring care pathways aligned with OOHC clinical frameworks and requirements
- Core activities focused on workforce capacity building, youth health engagement and staff health liaison services (described earlier)
- The youth engagement strategy comprised two visits to each residential house from the Senior Youth Worker and GP.
- After completion of all house visits, a mid-point meeting brought together senior headspace Frankston staff with team leaders at each site to review progress and make adjustments to the model.

What worked well in this model?

- Multiple access points and pathways into and through the service
- Mental health support pathways for young people
- Assertive outreach-based engagement model
- Warm referral through existing relationships with YSAS AOD outreach workers
- Popularity of youth programs like Martial Arts Therapy as an entry point to service
- Some headspace Frankston staff had experience in residential care and the OOHC sector

What remains challenging about this model?

- For some of the young residents, entering and/or using a headspace service can be stigmatising; having a youth engagement role is particularly important
- House staff and youth engagement was not systematically achieved - communication gaps resulted in the GP and youth worker team conducting outreach activity at times when no young people were available.
- Inadequate engagement of young people meant that relevant processes to ensure prioritisation were not established due to a lack of service registration and case identification. (headspace centres require client registration prior to accessing services.)
- High service demand at headspace made it difficult for young people and staff from SalvoCare Eastern houses to secure timely appointments, with waiting times sometimes 1-2 weeks.
- Limited service hours was an access barrier (Monday-Friday, business hours, preferred doctor often only available one day per week)
- The acuity of some young people's mental health needs could not be addressed through the headspace model, which has a focus on early intervention
- Ensuring that stakeholders understand that headspace is not able to provide a crisis response or acute interventions

Evaluation: telling the story and learning from experience

Evaluation framework

The project took a participatory and capacity building approach to evaluation.

As a pilot, we sought to understand the feasibility of required local system-level changes, the sustainability of the three models, and their contribution in the context of greater sector reform. We also sought to ascertain whether there were achievements in (i) local knowledge production; (ii) improved OOHC health system literacy; (iii) capacity building and ownership; and (iv) partnership development. Through story telling, this evaluation contributes to building the evidence around working with vulnerable populations and supports SEMPHN in its objective to commission effective services to meet local service gaps.

The overarching evaluation questions to be answered for the pilot:

- Do these models support improved access to primary care for young people living in residential OOHC in south eastern Melbourne?
- Are the models feasible and sustainable?

For each of the three pilot models, the objective was to describe each model and their unique features, and the way that those features support or constrain a medical home approach to optimising primary care for young people living in residential care.

The evaluation framework was designed to align with SEMPHN's chronic disease evaluation framework to support consistency in outcome measures. The framework was finalised with each pilot site in turn to ensure it met individual site needs.

The next report section on Insights, perspectives and promising practice reports on progress against this framework (page 24).

Table 1 summarises the sources of data used to inform the evaluation.

Table 1: Data sources

Qualitative Data
1. Monthly GP/youth engagement reflection sessions with set discussion guide
2. General practice meetings
3. Residential staff workshops
4. Ongoing communications with site project managers.
5. Interviews with key stakeholders
Quantitative data
1. Site activity logs
2. Training needs assessments
3. Training evaluations
4. Practice data
• Health assessment completion
• MBS item numbers
• Referrals

Limitations of the findings

While this evaluation framework was used as a guide, it was not possible to collect rigorous evaluation data on all measures given some of the constraints discussed below. In particular, only summary patient data from a primary care perspective (MBS and clinical data) could be accessed and not consumer data - the evaluation did not have access to the young people's perspectives on service access. Secondly, the headspace model requires young users to be registered service users, and the project was not successfully able to identify how many of the twelve people from the four SalvoCare Eastern houses became registered users of headspace Frankston. This limited access to summary patient data.

The following should be noted while interpreting findings from this report:

- This is a short-term pilot project
- The out of home care context
  a. The findings in this report are specific to the residential care setting in out of home care
  b. The young people living in residential care are aged 12 to 17 years (with some exceptions including a 10-year old in one of the participating houses)
  c. In the 12 months of the pilot, there was turnover of young people in several of the houses (Frankston, Elwood)
- Working with a vulnerable sector
  a. A residential care sector that is under-resourced and can be difficult to engage, with staff at risk of fatigue and vicarious trauma, and sites requiring investment in technologies, capacity building and data management
- Working with vulnerable populations
  a. Methodology did not allow for direct data collection from young people living in residential care. The timelines of the ethics approval process did not correspond with the project timelines. As such, efforts were made to collect information from secondary sources (care staff, clinicians, practice team) while acknowledging the limitations to this approach
  b. While these youth have high and complex needs, the pilot did not directly measure of health and wellbeing outcomes;[6] impact measurement was concentrated at a systems level, measuring primary health care service capacity to adequately target the cohort.

6 Measuring improvements in health and wellbeing for young people in OOHC include indicators such as mental health, physical health, quality of life, social connectedness, and independence and social skills. Specific measures can include reduced risk taking, improved stability, improved quality of contact with family and carers, greater participation in education and in extra-curricular activities in the community, and a significant improvement in sense of self

Insights, perspectives and promising practice.

What did we learn?

The learnings and challenges were significant during the piloting of these models. In the sites where the general practice team and the residential house team were engaged with the project objectives and with each other, there was important progress made on the development of sustainable relationships and medical home models. In the sites with a lack of engagement, there was little progress.

Table 2 provides a snapshot summary of the findings against the evaluation framework. Unless otherwise indicated, comments on findings address sites where the most progress towards a medical home model was made. Following the table is a more detailed discussion against each of the outcomes.

Table 2. Summary report against indicators in evaluation framework

Outcome 1: Improving access to services

Measures	Comments on progress against indicators
Indicator 1: Availability of primary health services	
• Services offering bulk-billing, after-hours, appointment options • Increasing the number of young people having a regular GP • Increasing the number of young people with a regular practice	• Yes- number of young people (YP) having regular GP increased • Yes - number of YP with a regular practice increased • Yes – when trust & safety increases, YP are more likely to access treatment (Eastern Medical Centre model most promising) • Yes – when GP visit onsite • Yes – when GPs complete after hours home visit • Yes – increased access to bulk billing • No – for headspace primary care clinic • No – staff capacity to build relationships with headspace for mental health care needs to be developed
Indicator 2: Equitable and enhanced access to services	
• Increasing the number of presentations for primary care (while reducing instance of 'doctor shopping') • Obtaining treatment when needed	• Yes – when bulk billing optimised • Yes – when trust and security builds, improving continuity and reducing 'doctor shopping' • Yes – when practice is close enough for YP to access to offer flexibility of attendance with carer or independent • No – when variable rates of engagement of YP (some YP within single house are being better supported than others, being left further behind) • No – house staff continue to need capacity built to embed universal health checks • Lack of staff education about health promotion is important barrier to better service access and outcomes for young people • Yes – all residential house staff trained
Indicator 3: Access to evidence based care	
• Participation in the OOHC Heath Assessment • Screening tools in general practice (HEADSS, SDQ, Achenbach)	• Yes – for those houses with increased completion of health assessments (strongest GP 1-on-1 relationships built) • Yes – when improving continuity & reduced doctor shopping • Yes – when upskilling of house staff • Yes – when supported by therapeutic worker in the house • Yes – headspace and general practice using screening tools (HEADSS, SDQ, Achenbach)

Outcome 1: Improving access to services (cont.)

Measures	Comments on progress against indicators
Indicator 4: Development and application of applied healthcare pathways tools in general practice, appropriate to young people in out of home care	
	• Still in progress • Yes – headspace • No - Houses need support in mapping local services

Outcome 2: Ensuring high quality services appropriate to this vulnerable population

Indicator 1: Services are integrated, coordinated and encompass continuity of care	
• Completion of GP Management Plan, Team Care Arrangements • GP Mental Health Consultation, completion of GP Mental Health Treatment Plan • Contribution to Multidisciplinary Care Plans, Asthma Cycles of Care, Diabetes Cycles of Care • Development of appropriate local referral pathways	• Yes – headspace model supports • Yes – when GP can attend staff meetings • Yes – GP Registrar model allows for follow up • In progress - Completion of GP Management Plans • Sometimes - GP Mental Health Consultation, completion of GP Mental Health Treatment Plans • No - Team Care Arrangements • No – no contribution to Multidisciplinary Care Plans. Need to review coordinating mechanisms. No shows and cancellations make difficult for clinicians to attend • No evidence of contribution to Asthma Cycles of Care or Diabetes Cycles of Care • No evidence of systematic development of appropriate local referral pathways except headspace
Indicator 2: Use of efficient information sharing and supportive systems	
• Access to general practice using data extraction/ analysis tool and/or online patient tools; using a recall and reminder system	• OOHC Health assessment template in progress, very well received in discussions • Yes – when patient files are flagged with OOHC (sensitive approach to address, context, medical data, carers) • No evidence of systematic data extraction/analysis tool • Yes - using a recall and reminder system
Indicator 3: Shared decision making	
• Patient involvement in care decision-making	• Yes – some examples from GP home visits, from continuity in care relationship • Yes – some examples from headspace • Still waiting on some clinical data from Elwood & Frankston

Outcome 3: Building service system capacity to manage the complex needs of this vulnerable population

Measures	Comments on progress against indicators
Indicator 1: Use of a care coordinator	
	• None of the models showed adequate progress in developing care coordinating mechanism. Needs to be greater coordination between case manager, house staff and general practice • No – headspace attempted unsuccessfully to contribute to case coordination but last-minute cancellations & change make impractical for clinical team • Need to find mechanism for increasing collaboration between Child Protection case manager and GP
Indicator 2: Receiving trauma-informed care	
	• Yes – headspace model but acuity of YP also outside of headspace expertise • Acuity of YP generally higher than all GP providers existing skill sets • CPD in trauma-informed care needed for all practitioners working with this population • Opportunity for GP to work more closely with therapeutic workers where available to continue capacity building • GPs who attend staff meeting are best placed to continue capacity building
Indicator 3: Treatment and care providers have an increased understanding of the complex needs of this cohort	
	• Resources have been identified for development: for General Practice, GPs and nurses; for residential care staff; and for young people living in out of home care • Resource focus on: a. Creating a safe environment/cultural safety b. Trauma-informed practice c. Communication skills d. OOHC health e. OOHC care coordination & data sharing
Indicator 4: Improved two-way coordination and communication between general practice and residential care homes	
	• Yes – some improved confidence in two sites but still in progress. Not telephone/fax/email contact • Trialling GP template will support • Increased subscription to and use of My Health Record • Work in progress. House staff need more training in My Health Record to facilitate YP engagement
Indicator 5: Reduction in the number of presentations to ED or ambulance use	
	• Unknown

Improving service accessibility for vulnerable OOHC youth: key themes[7]

The following section discusses the key themes that emerged from this pilot with reflections on identifying the differences between sites, early successes and opportunities moving forward. For each key theme, the sections discuss: what worked, what is yet to work, and opportunities moving forward.

The key themes are:

1. Working with vulnerability
2. Making OOHC-friendly general practice environments
3. OOHC-sensitive and inclusive practice
4. Building workforce capacity
5. Working together: data sharing.

Figure 4: A systems approach to optimising general practice for working with vulnerability

7 A note on language: We acknowledge a sensitive but deliberate use of the term vulnerable OOHC youth. While we wish to promote a de-stigmatising, strengths-based and empowering approach to working with young people living in residential out of home care contexts, the focus of this work is on systems-level change and learnings, to improve the capacity of primary health care providers to work with populations which face systemic determinants-driven barriers to accessing the care they need.

1. Working with vulnerability

Working with vulnerable populations, vulnerable sectors and in challenging settings requires a considered approach that:

- is person-centred
- ensures safe, welcoming and inclusive healthcare environments
- emphasises and provides the capacity for individual and system-level flexibility
- has adequate whole-of-team workforce capacity
- prioritises the development and/or refinement of processes while keeping a focus on outcomes
- expects (and engages with) complexity
- takes a systems approach.

This project has identified the following ten key building blocks that should underpin primary care approaches to working with vulnerable population groups:

1. Young person-centred approach
2. Priority access
3. Practice systems review
4. Cultural safety
5. Welcoming physical environments
6. Patient communications
7. Emphasis on confidentiality
8. Assertive contact
9. Multidisciplinary collaboration
10. Data sharing

We found that service accessibility for vulnerable OOHC youth is impacted by the following two factors, and are described in more detail in following sections:

- OOHC-friendly general practice environments
- OOHC-sensitive and inclusive practice

2. Making OOHC-friendly general practice environments

What worked?

A priority for improving engagement of young people in primary health care is to reduce fear, anxiety and discomfort. These feelings may arise from psychosocial and relational problems, previous negative experiences of health services, fear of the unknown and/or formal or professional adults, and over-stimulation. Services need to be delivered in ways that are welcoming and do not feel discriminatory to a young person.

It is important that general practices reflect on their policies, procedures, communication, and both waiting and care environments and how these might impact on services provided, or act as barriers, for vulnerable young people needing to access a service.

- Patient engagement options
  a. Flexibility in appointment options
  b. Flexible appointment making (website/phone app bookings; digital kiosk for registration)
- Front desk services
  a. First point of contact staff to be comfortable and support a young person to feel confident
  b. Depending on young person, familiarity is encouraged
  c. Should be experienced as inclusive (non-judgmental, no assumptions)
- Staff need to be sensitive to the OOHC context - issues of address, carer, medical records/ background, confidentiality/disclosure
  a. Informed and sensitive data collection (patient flagging system to identify OOHC patients)
- Reception and waiting areas
  a. Optimise feelings of safety and security (offer appointment times at start of day, or after breaks to reduce waiting times and exposure to crowds); availability of separate waiting room if available (low sensory environments)
- Communications with GP and nurses
  a. Acknowledgement of OOHC context and how this might impact on health service experience, and offering solutions (i.e. promoting development of medical home relationship, use of My Health Record, involvement of carer)
     i. Lack of background medical knowledge
     ii. Lack of medical records
     iii. Minimal access to health services previously
     iv. Distrust of health services
     v. Repeated health assessment procedures
  b. Discussion of confidentiality and disclosure, ongoing emphasis on confidentiality

In the Elwood site, a 14-year-old boy described by residential care staff as 'very complex and challenging' has a preference for the self-check in kiosk at the general practice which is a large multi-disciplinary clinic often has a busy waiting area.

The reception staff requested a list of residential care staff names and photographs and young people's names so they can familiarise themselves with the house. The residential unit received an A4 poster with the names of general practice staff, their photos and specialties so that young people can self-select GPs and familiarise themselves with the general practice environment before attending appointments.

The practice has a patient flagging system in its practice software, Zedmed. Patient flags have been added to indicate sensitivities around the OOHC environment, emphasise confidentiality and flag health assessment brief interventions.

At the Frankston site, the headspace centre is a youth-friendly service environment, developed by young people for young people. Approaches to care are voluntary, young person-driven, flexible, at the young person's pace, and young people prioritise the issues they wish to address.

> *If a young person has a good experience, if they feel they were heard, if they feel their needs have been met, then they will return (headspace youth clinic nurse)*

The remaining challenge for headspace is to adequately re-align stigmatising beliefs around using a mental health service reported by some young people.

Onsite engagement works

Assertive contact, or outreach, is a foundation of engaging with vulnerable populations. This is particularly true for the most marginalised and vulnerable groups (complex mental health, complex trauma, itinerant/homeless, Aboriginal and Torres Strait Islanders and some culturally and linguistically diverse communities). For young people in residential OOHC, it is driven by premises of trauma-informed care, person-centred practice, prioritisation based on vulnerability, and early intervention. Most of all, its foundational principle is 'engagement first'.

Two of the pilot sites used an assertive in-reach model to engage: Dandenong and Frankston, and stakeholders all reported significant benefits for the three-way relationship which underpins the medical home (care staff, young people and clinicians).

> *The GP was very hands on with our kids at the start and that made all the difference, was key to their engagement (House Manager)*

> *In my opinion, the ability for the doctor to visit at Jesson House in addition to regular clinic-based appointments has helped to foster a level of familiarity and trust between doctors, carers and residents. Such an arrangement, implemented more widely and in other facilities in the future, will likely be of benefit in improving health outcomes for residents. (GP)*

> *The outreach component broke down the engagement walls we need. We should encourage this, even if at a minimum for a meet and greet (Health and Education Assessment Coordinator, DHHS)*

While the timings of the latter did not successfully allow GPs to meet with young people, SalvoCare Eastern is still very interested in trialling onsite engagement in order to provide the consistency and stability the young people need.

> *It would be beneficial to build a relationship with the GP clinic next door to the house where there might be the option for the doctors onsite to conduct some outreach to our young people to assist in building rapport and become familiar with the young people at the house (Manager Residential Youth Services)*

The third site Elwood report that onsite engagement at the house would make a significant difference to the engagement of their young cohort. The community service organisation runs four homes locally, and can identify which cohorts of young people in which homes would benefit from onsite engagement in order to begin the process of trust-building more than others.

What is yet to work?

- Reception staff need systematic OOHC training
- No general practice environment audit conducted to review for OOHC-friendly environment
- Patient registration and prioritisation at headspace (the 12 young people have not been identified and not registered at headspace)
- headspace outreach activity to provide the flexibility and resources needed by a large number of residential units

Opportunities moving forward

- Formalising an OOHC-friendly general practice framework and OOHC-friendly general practice checklist/environment audit
- Involvement of young people to co-design this framework and for continuous quality improvements efforts
- Residential house care staff would like reception staff to take more active role in managing wait times (i.e. to actively speak to waiting young person to manage expectations)
- Work with OOHC young people to develop some approaches to communications to destigmatise headspace centres and the services within

3. OOHC-sensitive and inclusive practice

Care for young people living in residential OOHC needs to be informed by current understandings of trauma, attachment, socialisation and child development. This approach is not exclusive to the care staff in residential contexts but to the many and various people who form part of their larger wraparound care team.

All of these care team members, including the general practice team need to have capacity to work safely with the vulnerability that comes with people who may:

- Have complex mental health difficulties, including self-harming behaviours
- Abuse substances and be under the influence of a substance
- Be highly vulnerable to exploitation and abuse
- Have experienced neglect, physical and sexual abuse, have witnessed and/or subjected to family violence, and may have been exposed to antisocial family cultures
- Display reactive sexual behaviours
- Display criminal offending behaviours.

Approaches to OOHC-sensitive and inclusive practice has to be comprised of the following priorities.

Safety

The experiences and environment around a young person living in OOHC has to be purposefully designed to provide a basis for positive, safe, healing relationships which are sensitive to the complex needs arising from the impacts of abuse, neglect, adversity and separation. Relationships with adults, with people in power and with professionals such as general practice teams are particularly important.

Building this safety can be individual-specific and was approached in different ways in different sites.

At the Elwood site, house staff have begun to experiment with different familiarisation approaches to introduce young people to the safety of the general practice. The clinic is now included in neighbourhood walks during a young person's orientation to the house and neighbourhood when they first arrive. One of the practice nurses has established an open-door policy where she welcomes any young person to be brought in to be introduced if her door is open. The house staff are also encouraged to bring a young person in to be introduced to a GP for a few minutes when walking past the practice.

At the Dandenong site, the approach to building safety and confidence was driven by the development of initial relationships between the GP and house staff, and by the GP conducting site engagement visits, where she was seen in a non-clinical and non-threatening role, getting to know the house and its occupants without pressure for clinical care.

Consistency

A key priority for these young people is consistency in their care team (e.g. medical, case management, mental health). Consistency is needed to build relationships which in turn builds trust, which leads to engagement. With a long-term view, young people will be able to leave residential care more confident, having experienced a network of consistent and reliable care from a support network from which to continue drawing on as they become independent.

At the Frankston site, the emphasis of the model of care is on flexibility to real world conditions but that building trust is a compounding process

> *We offer multiple approaches to building trust, but significant things happen to these young people all the time. Their journey can be derailed at any given moment, at any time during their service journey. We complete a health check and HEEADDS assessment anywhere in the service, and the rest will eventually follow, but timeliness can be difficult (headspace)*

What worked?

Developing relationships with general practice staff and providing an environment that prioritises safety, consistency, stability and a sense of security is critical.

The goal is for the general practice team to be sensitive to the impacts of lived experience of trauma and to focus on each young person's strengths, capabilities and competencies; and on the development of their social and emotional skills, resilience and self-esteem.

In the Dandenong site, where there was one GP dedicated to the four young people in the house, the relationship developed the fastest. Contributing factors were:

- Youth-friendly approach of GP (language, appearance, attitude, youth-directed conversation) with a youth-directed communications approach: informal but direct[8]
- GP building a relationship with the carers
- Young people witnessing the GP build a relationship with their carers
- GP coming onsite to the house

See Larter recommendations on optimising youth access to sexual health services for Family Planning Victoria. Youth consultation data including with vulnerable youth (ATSI, CALD, LGBTI, adolescent males) suggested clear preference for general practitioners to use youth-directed communications techniques (ie 'tell me straight')

- GP available for afterhours home visits under certain conditions of vulnerability (for example, young person refusing to leave the house or attend a general practice)
- GP proactively follows up health concerns – by contacting external services and by visiting the house intermittently for brief visits for assertive contact

The young people have the experience of being cared for by the GP. They experience their relationship with the GP, as an adult, as one of care (Residential house care staff)

In the Elwood site, where there was a small team of GPs and nurses dedicated to the four young people in the house, one GP in particular had a reputation among the young people as a safe, reliable and sensitive provider, and was favoured for many appointments. The young people, the residential house staff and the general practice team all identified this doctor as the unofficial preferred provider. (Of note, this same doctor had the same reputation among other residential care houses in Frankston during a previous placement at a general practice there).

The first three times a young person comes to me can often be really hard, and there won't be much trust or revelation. It can take three visits before the young person trusts me enough to reveal what is really bothering them, and we begin working together from there (General Practitioner)

Building relationships

The GP and practice nurse play a different role in the lives of these young people than a standard doctor-patient relationship. This role can work two ways, and needs to be managed to ensure it is safe and value-adding for the young person. For these young people who live with different types of attachment disorders and behaviours, a professional adult can be intimidating or threatening.

These relationships however can also be therapeutic: the development of strong relationships with staff, coupled with clear boundaries, can offer the young people a sense of safety and belonging, and can reap rewards for the young person and their health.

At the Dandenong site, the relationship between GP and young person was identified as the primary driver of outcomes by house staff, by the GP and by the young people.

The relationship is primary (residential care staff)

The GP 'caring' works. When the GP stops by the house to check in, unexpectedly, or follows up on issues discussed during a consultation, the young people get a sense of being cared for. It builds a relationship, builds trust and confidence, and the young people are more likely to disclose (House team leader)

These young people are very specific about which doctors they will engage with and not engage with. Very quick to determine which doctors they are willing to invest more time in. They are also very happy to provide feedback on doctors that 'work' or 'don't work', but the actual relationship build remains slow. The trust building process has to take time. (House team leader)

Optimising carer relationships

There is no consistent approach across residential houses to the support of carers in GP appointments. It is both individual to the young person concerned and to the clinical issue at hand. Two different approaches were captured with good outcomes for young people:

1. Carer-as-parent in therapeutic relationship: attends appointment and contributes 'coordinating' parental role (more common in the therapeutic home environment)
2. Young person builds the confidence to access healthcare independently of a carer and builds relationships with particular GPs/nurses/practices to trust those relationships without their carers

The medical home approach to working with carers will develop over time.

Patient activation

The clinical priorities for a medical home identified by the participating general practitioners are:

1. Catch up immunisations
2. Completing OOHC health assessments
3. Active mental health support/intervention
4. Risk assessment/harm minimisation/behaviour change
5. Prevention

Some of the early outcomes seen have been in patient activation, which has been directly attributed to GP relationship building. The Dandenong GP coming onsite achieved very fast engagement in:

- The treatment of pre-existing conditions resistant to treatment
- Completion of health assessments (initiated by young people themselves)
- Treatment of sensitive sexual health issues
- Patients proactively seeking health care appointments.

The residents know who their doctor is and know they have someone to call on for medical issues (General Practitioner)

[Building a trusting relationship onsite at the house] has led to engagement about mental health, sexual health and general health issues which may have not been at all reported by residents had the therapeutic relationship not been developed. (General Practitioner)

We have a cohort of four (house residents). Two are system enthusiasts. Happy and willing to go to the doctor at any opportunity. Two are reluctant and refuse. These latter two would benefit from GP engagement, coming onsite would be ideal (Area Manager Southern Services OOHC)

At the Dandenong site, the female GP was able to engage a young woman at risk of sexual exploitation in the treatment of an STI which she had avoided treating for some time. Over a number of sessions, the GP delivered a behavioural intervention and the young person self-reported avoiding sexual activity for several months.

The evaluation was unable to extract accurate Medicare (MBS) data from two of the pilot sites. The Dandenong site MBS item numbers tell us about the most common clinical presentations:

Table 3: Frequency of MBS items for 4 young people in 10 month period at Dandenong

MBS Item Groups	*MBS Item Numbers*	*Frequency between 23/09/2016 – 26/07/2017*
Group A1 – Standard Consultations	Level B	18
	23	2
	24/1	2
	24/2	3
	5023/1 (after hours home visit)	
	Level C	7
	36	2
	37/1	3
	37/2	1
	5043/1 (after hours home visit)	
	Level D (Initial & Comprehensive Health assessments)	4
	44	0
	47	
Group A14 – Health Assessments	Preparation of GP	1
	Management Plan (721)	
Group A15 - Chronic Disease Management	Coordination of Team Care Arrangements (723)	1
Group A18 – Incentive Items	Preparation of GP Mental	1
	Health Treatment Plan (2700, 2701, 2715, 2717)	

From the GP interviews at this general practice, we know that consultations included the following presentations during ten months of pilot participation:

- Mental health
- Sexual health (STI; Implanon)
- disclosed sexual abuse
- Skin (skin infections, nail infections)
- Foot physiotherapy
- Smoking cessation
- AOD (ice)
- Parental mental health, including suicide attempt
- Acute (sore throats and upper respiratory infections)
- Eating (not eating, eating too much sugar)
- Food allergy (anaphylaxis)

There have also been some early outcomes reported in care continuity and coordination. Outcomes reported by staff as a result of establishing a relationship with one general practitioner:

- *We don't have to shop around for a doctor that will see us*
- *We haven't been banned from this doctor because of DNSs [Do Not Shows]*
- *We are having to cancel fewer appointments*
- *We don't have medical records all over Dandenong for the last 12 months*
- *We have a stable base from which to now strengthen our medical approach: we can now catch up on immunisation history and collect background medical data*

At the Frankston site, which the headspace centre is set in the context of a multidisciplinary and co-located youth services centre, warm referrals among services have contributed to accelerated trust and safety. The YSAS AOD workers in particular are well known and liked among the Frankston OOHC cohort, and can act as coordinator to handover care to the youth clinic. One of the positive stories to emerge from SalvoCare Eastern houses was the independent service access at headspace by one of the young men with particularly complex and challenging needs. A second young man has very significant trauma/grief/loss history and current AOD abuse. Staff had referred him to counselling but he was unwilling to discuss his mental health with the clinician. In the multidisciplinary setting, the clinician was able to engage him around changes and goal setting and offer easy access to AOD services and primary health.

For some young people, the medical home relationship might need to occur one individual at a time, starting with a GP or nurse, before shifting front-of-house and/or to systems, and eventually whole-of-practice.

What is yet to work?

- headspace capacity for flexibility and prioritisation

I think the key here is consistency of response and a medical practitioner and headspace were unable to provide this

Our young people were more inclined not to attend the headspace office due to it being known by most young people as a place you go for mental health. I definitely think the branding is something that needs to be looked at for our young people and a Youth Health Care Clinic I believe is the best way to present it to the young people we care for.

I know that we tried on many occasions to introduce young people to the Headspace centre but unfortunately it just didn't go to plan.

- Establishing a feasible system for data sharing/ information exchange. Medical home should be provided with comprehensive medical background and data, extracted from the OOHC entry data that accompanies the young person
- Optimising an approach to missed appointments. Do Not Attends should be assertively responded to as an indicator of vulnerability

Opportunities moving forward

- Co-designing a framework, checklist and capacity building strategy for OOHC-sensitive and inclusive general practice
- Identifying GPs, Practice Nurses and General Practice that are willing to engage in some level of onsite home visits: (i) for initial relationship engagement and (ii) under certain conditions of vulnerability (for example, young person refusing to leave the house or to attend a general practice)
- Exploring opportunities for 'OOHC preferred provider GPs' to contribute to workforce capacity development activity (developing or delivering content) to share practice wisdom
- Embedding sensitive and inclusive practice at whole-of-practice level, shifting the dial from individual to system to practice
- Proactive care
  a. Optimising the medical home's role in recognising factors that contribute to risk and intervening earlier to reduce or prevent further harm
  b. Young people's voices must be heard, valued and acted upon, and young people must play a key role in setting their own goals and the direction of their treatment and care plans
  c. Eventually as the relationship strengthens and matures, aiming towards shared decision-making towards that focus on and building trust in other health care professionals/ health system, building health care and self-care literacy, foundations of preventative behaviours and decision-making
  d. A collaborative and empowering teaching approach that uses the general practice environment as an additional support for young people to learn life skills, pro-social behaviours and self-management towards independence/leaving care

4. Building workforce capacity

i. Building residential care staff capacity

During the course of residential house and staff engagement, a staff training needs analysis was completed at each of the three pilot sites to understand the training needs for residential services to better understand the key health issues and health assessment requirements for young people and how to navigate primary health care (see Appendix 2),

The priority training needs identified were:

- Understanding the need of the Preliminary Health Check and Comprehensive Health and Developmental Assessments
- Meaningful use of the LAC, CRIS and record keeping to support health assessments
- Understanding each other's roles in achieving clinical assessment outcomes
- Engaging general practice (shared care, key Medicare item numbers, making appointments)
- My Health Record
- Medicare and billing
- Accessing other health services/local service pathways.

A brief staff training session was prepared and delivered at each site, responsive to the needs and format identified by each pilot site.

- Dandenong – GP-led interactive question and answer discussion with whole staff team
- Elwood – Nurse Educator and Practice Nurse interactive question and answer discussion with permanent staff team
- Frankston – GP training session to whole staff team from four houses.

The training sessions were well evaluated but were also seen as a small step in what needs to be a more universal and systematic approach to building primary health care capacity in the residential care workforce. Staff need training embedded into an orientation package, they need access to a resource pack, and need access to ongoing health care professional development. The next phase of development of this work needs to continue to concentrate on building residential staff capacity to engage young people in accessing health care. This is further discussed in the recommendations.

i. Building general practice team capacity

The priorities identified across all three pilot sites for the professional development of the primary health care response to young people living in out of home care are as follows:

Priority	Topics
Youth-friendly services	Provision of youth-friendly services
	Assessment and management adolescent health issues
	Orientation to youth models of care and pathways (e.g. Headspace)
	Undergoing working with children checks
OOHC-friendly services	Appreciation and sensitivity to the out of home care environment
	Understanding of OOHC frameworks and guidelines
	Understanding of OOHC MBS billing
	Understanding residential care: understanding the clients; understanding the staff constraints
	Managing medico-legal issues
Trauma-informed practice	Trauma-informed communication skills to support the young person to feel safe and facilitate engagement
	Management of high-risk young people, especially young people aged 12–17 years who experience complex emotional and behavioural difficulties; appreciation of necessary therapeutic interventions frameworks informed by attachment, trauma, neurobiological development and resilience theories
	Recognising factors that contribute to risk and intervening earlier to reduce or prevent further harm

There is currently very little available in CPD tailored for this cohort of youth patients that brings together the OOHC sector understanding with the communication/engagement skills required, and the clinical complexity. The approach to development has to be one of partnership between the primary care sector and DHHS Child Protection, underpinned by some therapeutic expertise (such as Australian Childhood Foundation or Blue Knot Foundation).

Appendix 3 provides a list of key resources identified that need to contribute to the development of resources and capacity building in these two sectors.

5. Working together: data sharing

A key priority for improving the primary health care system response to young people in residential out of home care is improved inter-sectoral collaboration. Responsibility for supporting these young people's safety and wellbeing needs to be shared through collaborative partnerships across all sectors. This collaboration needs to be intentional, resourced and systematic. The primary health care sector needs to be incorporated into an interdisciplinary team that includes Child Protection, Out of Home Care, Child and Youth, mental health, and acute care.

The largest gap and challenge is the lack of adequate effective communication and data sharing, without improvement of which few gains can be made in the long term. Both residential care staff and GPs reported the need and benefit of appropriate data transfer between the residential house and the general practice clinic, to provide some contextual clinically-appropriate background information about a young person entering the care of the general practice. From the GPs point of view, often working in contexts with no previous medical history availability, having access to any physical/developmental/psychosocial summary is clinically important. From a therapeutic point of view, access to contextual data facilitates delivery of trauma-informed practice.

We have so many high risk and complex young people, and we don't receive any background information to support the delivery of their care and it sometimes takes six months to receive any information (headspace)

For every young person, we want a page with the date of their last dental check, last health check, last eye check, all their meds. We waste so much time trying to collect all this information when it should be provided (House care staff)

We really want to see an optimised use of CRIS in which all stakeholders use it the same way and have equitable access to and use of the CRIS data. CRIS is the most comprehensive source of data but everyone needs to use it the same way (DHHS Health and Education Assessment Coordinator)

During the course of this pilot, an approach was led by DHHS Health and Education Assessment Coordinator to develop a template document that can be extracted from existing documentation about a young person upon entry into the house (specifically, the Essential Information Record) to be sent to the medical home ahead of a young person's first appointment at the medical home. The template is designed for house care staff to auto-populate with health information from Essential Information Record (supported by any additional information available from the Placement Referral), and is comprised of the following minimum key information:

- Personal summary
- Summary of consents
- Residential care placement background: this includes a summary of key background information that is important for the health care of the young person
- Health summary: this provides a summary of the health information available for the child/young person.

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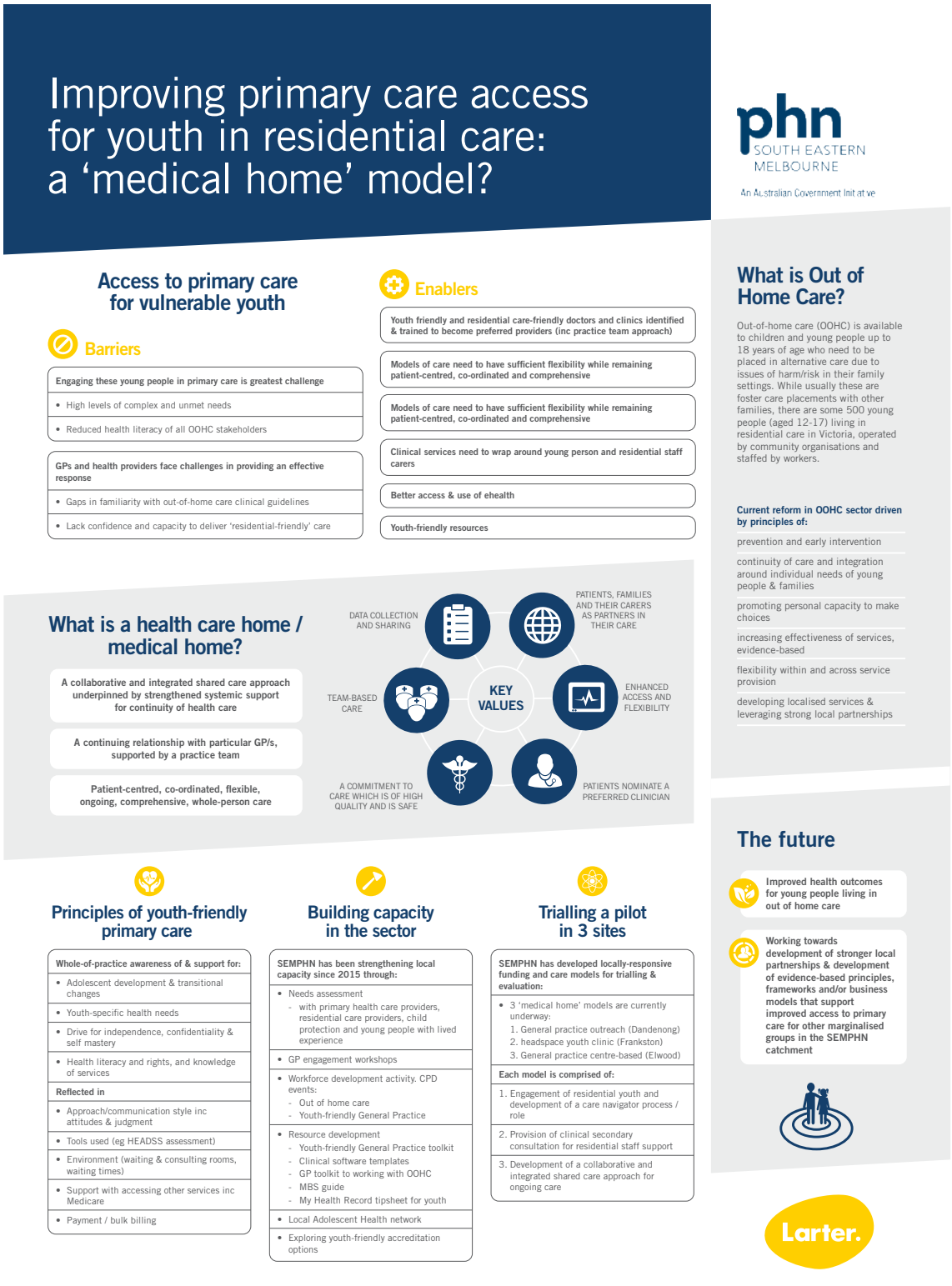
Appendices

Appendix 1: National Primary Health Care Conference 2016

Poster on Improving primary care access in youth residential care: a 'medical home' model? for NPHCC 2016



Appendix 2: Training needs analysis

- What training/resources do Avoca staff team need to support them to better support young people to: (1) complete their mandated health assessments, and (2) respond to arising health needs?
- What training/orientation to health and health assessments do staff receive?
- What are the priorities for capacity building?

☑	General orientation to primary care/general practice: Understanding General Practice and navigating primary health care system (e.g. Billing, appointment scheduling, urgent appointments, Medicare, negotiating payments; identifying youth-friendly services) • Medicare cards, Medicare & billing • Accessing other health services • Understanding My Health Record
☑	Collection of medical history of young people entering residential care • Strategies for engaging parents/carers in the collection of health histories
☑	Using Looking After Children to improve health
☑	Specific health issues (AOD/sexual health/mental health/smoking/other)
☑	Understanding each other's roles in health: Residential worker & Child Protection Worker. Creating more collaborative approaches to health with Child Protection/case workers/etc
☑	Understanding health checks/assessments
☑	Negotiating consent processes for sharing medical records; strategies for overriding consent issues
☑	Motivational & engagement techniques for mental health care
☑	Empowering independence and transition to leaving care
☑	Other

Appendix 3: Resources for consideration

Some key resources identified that need to inform

- Vulnerable children (www.health.vic.gov.au/childrenatrisk)
- Healthcare that counts: A framework for improving care for vulnerable children in Victorian health services
- Children at Risk Learning Portal Resources
  - http://vulnerablechildren.e3learning.com.au
  - Free course in protecting vulnerable children for health professionals
  - Pathway to Good Health assessments
  - Rights of Children and Young People in Health Care
  - Science of early childhood
- OOHC Toolbox
  - Tailored information & guidance for carers and workers
  - Identify & respond to: substance use; mental health; sexualised behaviours; anger & aggression; self-injury; suicidality
  - Foundations of: drugs, adolescent development, attachment, trauma
- Pathway to Good Health resources:
  - Series of program resources (carer flyer, parent flyer, general flyer, new checklist, CT2, background, health check guide)
- Health Pathways Melbourne – Young People in Out of Home Care in north-west Melbourne
  - For GPs, provides clear and concise guidance for assessing and managing a patient with a particular symptom or condition. Referrals to services in the local health system. Each pathway is evidence-informed, reflects local reality, and aims to preserve clinical autonomy and patient choice.
- DHHS Immunisation for special-risk groups: OOHC
  - Https://www2.health.vic.gov.au/about/publications/factsheets/immunisation-children-out-of-home-care
- Child Health Passport, Queensland
- Victorian Child Protection Manual
  - Advice regarding who is authorised to consent to certain types of medical examinations and medical treatment for a child depending on their legal status
  - http://www.cpmanual.vic.gov.au/advice-and-protocols/advice/health-medical/consent-medical-examination-and-treatment
- CREATE Foundation
  - Working with children and young people in care who identify as LGBTIQ
  - https://create.org.au/wp-content/uploads/2015/07/VIC_createing-Equality-Dos-Donts1.pdf

Appendix 4: General practice medical home participation requirements

1. Staff resources
   a. Portfolio staff (GPs, practice nurses, systems support such as Practice Manager or reception)
   b. Meeting schedule:
      i. Initiation & gap analysis workshop
      ii. Informal site visit (2-3 staff)
      iii. headspace meeting
      iv. Delivery of informal training sessions for house staff (primary care 101)
      v. 6-monthly debrief lunch
   c. Availability for onsite engagement/home visits/nurse outreach (if necessary)
2. Systems-level review
   a. Prioritising patient files
      i. Add sensitivities flag (parents/carers; address; confidentiality; medical history; health assessments)
      ii. Bulk billing availability
      iii. After hours availability/pathways
      iv. Educate use of emergency/ambulance
   b. Support My Health Registration (support consent form transfer)
   c. Train front-desk/reception staff on sensitivities
   d. Support Transfer of Medical Records data
   e. Embed OOHC health assessment templates
   f. MBS item availability
3. Training for practice staff
   a. Youth-friendly practice
   b. OOHC sector & OOHC-inclusive general practice environments (including OOHC health assessments)
   c. Systems approach to working with vulnerability
   d. Trauma-informed care & communications
4. Review options for role in care coordination & increased multidisciplinary collaboration
   a. Support interdisciplinary collaboration with mental health, child protection, specialist allied health (dietician, speech pathologist, physiotherapy, exercise physiologist), other specialist service providers, drug and alcohol, youth justice, Aboriginal workers and peer support workers as needed

Additional considerations

5. Existing relationships with carers and services that are important to the young person will be acknowledged, valued and maintained where possible
6. Person-centred and shared decision-making towards preventative care
   a. The focus for the medical home and the building of a key GP relationships is about strengthening a person-centred and shared decision-making approach.
   b. In supporting OOHC-inclusive general practice environments and building medical home relationships, the aim is to focus on the strengths, needs, goals and aspirations of each young person through individualised holistic assessment. The general practice setting, like the residential setting, should aim to keep the young person engaged and focused on their own safety, healing and growth. Longer-term outcomes should see improvements in mental health, physical health, quality of life, social connectedness, and independence and social skills

The clinical priorities for a medical home identified by the participating general practitioners are:

1. Catch up immunisations
2. Completing OOHC health assessments
3. Active mental health support/intervention
4. Risk assessment/harm minimisation/behaviour change
5. Prevention

Appendix 5: Leaving care: supporting independence and health literacy

GPs have identified they are well positioned to provide some of the primary health care training to young people transitioning out of residential OOHC.

When a young person leaves residential care to become an independent adult when they turn 18 years of age, they can need support in accessing health care and navigating a complex system, in addition to general self-care and avoiding high-risk behaviours.

Planning for independence at age 18 requires the development of life skills, motivation for supporting physical and mental health, and ongoing prevention and harm minimisation in sexual health and substance use. Key for young people leaving residential care is the development of connections and support systems with a network of caring and supportive professionals.

A medical home can support this transition and exit planning to independence in a number of ways, for example:

- Support and resourcing for accessing health services
  a. Information about and referral to
     i. Available services (including counselling): written information about available universal and specialist resources, services and referral points
     ii. Includes information on GPMHTP and stepped care services
     iii. Mainstream services/public health system
     iv. Specialist services
- Building health literacy
  a. Service accessibility (various eligibility pathways; income assistance; concessionary access; advocacy services)
  b.. Data access/management:
     i. Accessing own personal information from relevant agencies
     ii. My Health Record
- Availability of ongoing medical home services

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