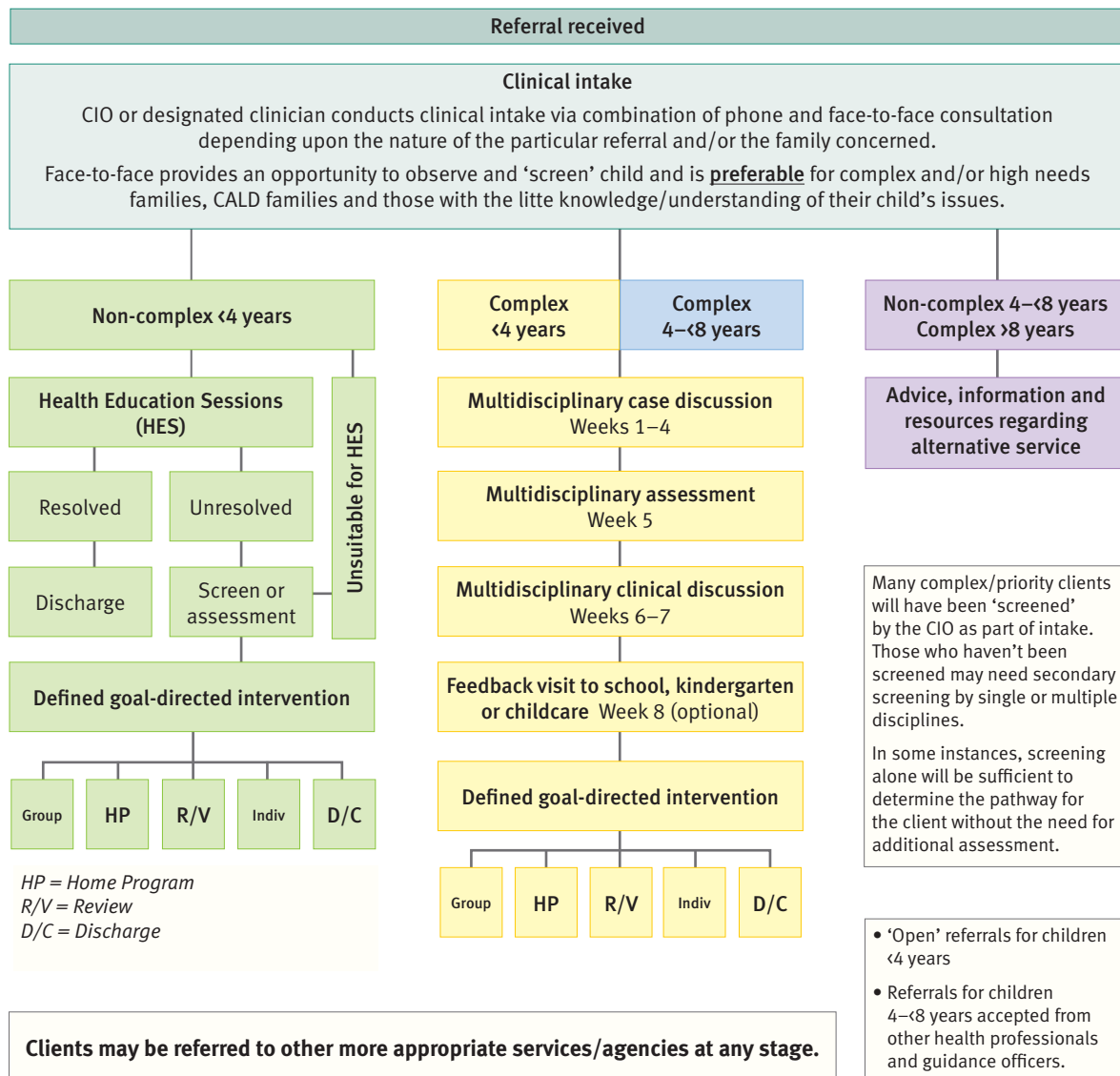


## 4. The Developmental Model of Care (DMOC)

The following flowchart depicts a generic representation of the model of care as implemented by Metro South during the trial.



The trial was flexible enough to allow demonstration sites to vary certain elements of the model of care according to the local context as determined appropriate by local management and clinicians. These variances occurred with regard to:

- access
- clinical intake processes
- health education sessions
- clinical care pathways.

Please refer to Table 3 for additional information.

**Table 3: Variations in model elements adopted during the DMOC trial**

Model elements	Variations	Gold Coast	Metro South	Sunshine Coast
Access	Upper age limits for entry into service	10 years	<8 years	6 years
	Referral source for >4 years	Accepted only from Private paediatricians and child psychiatrists*	Accepted only from other health professionals	Open referrals – accepted from parents when supported by GP, CHN, teacher, etc.
	Definition of complexity	Complex developmental and learning problems requiring the involvement of three or more health professionals	Developmental difficulties across one or more domains which is having a significant impact on the child’s ability to function in multiple settings and/ or their overall health and well-being#	Complex developmental and learning problems requiring the involvement of three or more health professionals
Clinical intake	Mode of intake	Predominantly phone with some face-to-face consultation	Predominantly face-to-face with some phone consultation	Triage based on referral information and/or phone consultation
	Use of pre-intake Background Information Questionnaires (BIQs)	N/A	Yes	N/A
	Initial appointment ~	N/A	N/A	Yes
	Dedicated administrative support	N/A	Yes	N/A
Education sessions for parents/carers	Timing within patient’s journey	Mandatory prerequisite for entry to service^	Mandatory prerequisite for entry to service^	Integral part of therapy group
Clinical care pathways	The range of streams or pathways of clinical care offered	EIPP, MEIT, MAIP and Families Program	EIPP, MEIT and MAIP	MAIP (0–6 years)

\*Will also accept referrals from medical officers, some GPs and community child health/school health nurses (CH/SHN)

^Excludes parents/carers unlikely to benefit from/cope with group-based education (e.g. CALD) and certain conditions (e.g. stuttering)

# In determining complexity, consideration is given to the impact of pre-disposing psycho-social and environmental factors and/or the need for other services such as Dietetics, Audiology, Podiatry and Early Intervention Parenting.

~ Trial of a standard transdisciplinary initial appointment with family-centred approach to improve engagement and facilitate best possible outcomes for children.

For the duration of the trial, a number of clients that commonly present to CDS for physiotherapy and speech pathology management were deemed non-developmental and excluded from allocation/participation in the EIPP, MEIT and MAIP pathways including infants with plagiocephaly, torticollis, talipes (all in the absence of concomitant developmental difficulties) and/or feeding issues and older children with behavioural toileting issues. Where appropriate, infants were fast-tracked to the relevant discipline via the CIO as a matter of urgency.

While an agreed definition of complexity and core business for CDS is integral to achieving statewide consistency, it was unable to be achieved during this trial. Although the majority of CDS appear to have already adopted the definition of complexity as implemented by the Gold Coast HSD, additional work is required in this area.

Each of the participating HSDs implemented a slightly different definition of the level of complexity of each referral received. For example, a complex referral on the Gold Coast was defined by the child having ‘complex developmental and learning problems requiring the involvement of three or more health professionals’. The Sunshine Coast’s definition was similar, whereas a complex referral in the Metro South trial was defined as having ‘developmental difficulties across one or more domains which is having a significant impact on the child’s ability to function in multiple settings and/or their overall health and well-being’. In determining complexity, consideration was given to the impact of any pre-disposing psychosocial and environmental elements and the requirements for dietetics, audiology and/or podiatry services were also considered relevant to the child’s developmental difficulties.



Unless otherwise stated, children of Aboriginal, Torres Strait Islander or Australian South Sea Islander descent should be prioritised in line with the principles of closing the gap (National Partnership Agreement for Indigenous Early Childhood Development 2009–14).

Although the DMOC described was developed for use in metropolitan and larger regional CDS with dedicated CIOs and in some cases dedicated AO support, the various components of the model can be adapted for application by any service/team.

The definitions of the various components of the DMOC implemented during the trial are detailed in Appendix 2.

## 5. Clinical intake

Intake in this instance is considered to be an essential clinical component of service delivery, rather than simply an administrative process.

### 5.1 Role of the clinical intake officer

The primary purpose of the CIO position is to coordinate access to the child development service/team for families of children referred to the service with developmental and/or non-developmental issues. In particular, the CIO position aims to:

- minimise the time elapsing between receipt of referral by the service and first contact with the child's family to commence the intake process: ideally, the intake consultation should occur within one to two weeks of the referral being received by the service
- assess a child's eligibility for services and where appropriate, redirect the family to a more suitable service provider
- make a preliminary clinical judgement of the extent and severity of a child's developmental or other issues via an initial phone or face-to-face screening and recommend an appropriate clinical care pathway for addressing the issue/s
- where indicated, initiate a more comprehensive and coordinated multidisciplinary assessment process to identify the range and severity of the child's issues and appropriate intervention strategies.

Where the CIO determines that a child is ineligible for services, it is appropriate for the CIO to provide clinically relevant and time-limited support to assist a family to access other services.

However, the CIO role is not that of a case manager. Appropriate assistance will generally include:

- provision of verbal advice during the phone or face-to-face consultation on possible alternative services (e.g. where a child is deemed 'ineligible') and how best to access them
- arranging for a resource/information pack on relevant alternative services to be sent to the family
- it may also be appropriate for the CIO to make a formal referral to another service provider such as a paediatrician.

Please refer to Appendix 3 for a flowchart depicting the decision-making process for CIO.

Where it is evident that a family requires more intensive assistance to access other services due to factors such as intellectual disability, cultural issues, socio-economic difficulties or similar then the CIO should notify the original referral source and ask them to assist their client. Alternatively, it may be appropriate for the CIO to formally refer the family to another service that is better equipped to provide a case management service.

The CIO role requires a very experienced allied health professional who is able to utilise their comprehensive transdisciplinary knowledge and clinical expertise in paediatrics to make informed judgements regarding a child's eligibility for services, need for intervention and the most appropriate clinical care pathway. In particular, the CIO will need to:

- have a clear understanding of professional roles within the team and externally as well as referral processes and community resources
- utilise effective questioning techniques and experience working with 'high risk' families to engage with families and identify family concerns.

A generic role description for the CIO position (Child Development Service) is provided in Appendix 4.

### 5.2 Clinical intake processes

Where resources permit, the intake process should preferably comprise an initial consultation between the CIO and the child's parent/carer at a scheduled time. This generally takes the form of a planned phone consultation but may be a face-to-face interview if a phone consult is not appropriate for any reason; e.g. language issues. The intake consultation comprises:

- preliminary assessment of the extent of the child's issues/problems
- relevant medical history
- any previous assessments or diagnoses.

Based on this information, the CIO is then able to make an informed decision on:

- the child's eligibility to receive services from the child development service/team
- the most appropriate clinical care pathway for the child
- the range of disciplines that should be involved in assessment of the child.

For children with more complex developmental issues who are recommended for either the MEIT or MAIP pathways, the recommendations will be discussed and reviewed at case discussion as appropriate. Similarly, if the CIO is uncertain regarding the most appropriate care pathway for any child, this can also be discussed by the multi-disciplinary team at case discussion.

If the CIO deems a child is ineligible to receive services, the family will be informed at the conclusion of the consultation. Should the CIO require clarification regarding a child's eligibility status, then the family should be advised verbally of the decision as soon as possible after the consultation. A formal letter and resource manual should be mailed to the family as soon as possible.

Clinical intake is further complicated in paediatric allied health (AH) services where it is necessary to make the distinction between developmental and non-developmental referrals including those relating to acute inpatients and outpatients, primary care and ambulatory care. An integrated clinical intake process whereby the CIO or designated clinician triages all referrals received is the most efficient option provided the response time for acute inpatients and/or urgent outpatients is suitable. Referrals of this nature are then redirected to the appropriate discipline senior for allocation.

In those services/teams that lack the capacity for a dedicated CIO, it is essential to have a formal process whereby children/families have their assessment needs identified at first contact to enable streaming into the appropriate pathway (Johnston & Colley, 2009). As an alternative to a dedicated CIO, services might consider using any of the following (either individually or in combination):

#### Using a standard referral mechanism/template

- In some services, the lack of available resources demands that clinical intake and triage is conducted primarily based on the clinical information provided by the referring officer (e.g. GP, paediatrician). However, the quality of referral information can be variable. Development of standardised referral forms which contain sufficient and accurate

information to enable clinical decision-making (regarding prioritisation and allocation) without the need to gather additional information is recommended. Adoption of a standard protocol for minimum referral requirements (e.g. GP referral template) improves both the efficacy and efficiency of the triage process. Most GP practises now utilise clinical software packages that automatically populate referral templates with the required clinical information. Contact your local division of General Practice within General Practice Queensland (GPQ) for additional information.

An example of an electronic GP referral template is provided in Appendix 5.

#### Having a duty roster for clinical intake

- Any health professional could participate in a clinical intake roster (including AH, nursing or medical professionals) provided they are adequately trained; however it is not recommended that an inexperienced practitioner (as is sometimes the case in rural and regional services) or an administrative officer provide the clinical intake role. There would need to be specific cross-disciplinary competencies developed for new staff and those new to the service taking on an intake role (Johnston & Colley, 2009).

For CDS situated outside the south-east corner, a centralised multidisciplinary intake process could be considered for each region through an agreed service model, dependent on the particular service level, staffing allocation, skills complement and level of complexity of client services targeted (Child Development Working Group, 2010).

#### Utilising screening processes including:

- first clinical appointment where clinicians who undertake the first assessment with the child/family also conduct a brief global developmental screen
- 'drop-in' clinics (typically held in community health centres at set times) where clinicians offer a brief global developmental screen to the child and their family
- Routines Based Interview™ developed by Robin McWilliam, PhD in order to:
  - become acquainted and establish rapport with the family





- communicate to the family that intervention is a system of supports and services to assist them in helping their children develop and learn
- establish a welcoming and respectful climate for family members and caregivers as equal members of the team
- gather information about the child and family’s everyday routines and activities and the child’s behavior and interactions with others in those contexts
- learn about the family’s formal and informal supports
- assess the functional strengths and needs of the child and family
- help identify functional outcomes for the child and family
- collect relevant information to help collaboratively plan and write strategies/ activities, services, and supports to address outcomes and enhance participation and learning in natural environments
- help identify the criteria, procedures, and timelines used to determine progress toward achieving each outcome
- identify transitions that the child and family may be facing.

Further information regarding Routines Based Interview™ is available at: [brookespublishing.com/newsletters/downloads/McWilliam\\_RBI.pdf](http://brookespublishing.com/newsletters/downloads/McWilliam_RBI.pdf)

### 5.3 Use of Background Information Questionnaires

Findings from the DMOC trial confirmed that use of a pre-intake background information questionnaire (BIQ) significantly increases the time interval between referral and intake (Bernie, 2008; Girle, 2010). Additionally, data available for Brisbane South demonstrated that not only were there delays associated with return of the questionnaires but also considerable delays in forwarding the questionnaires to families following receipt of the referral.

In addition to delaying intake, Bernie (2008) also concluded that requiring families to ‘complete lengthy paper-work before their eligibility is considered creates a significant access barrier for children whose care-givers have literacy and/or communication issues. Families from culturally and linguistically diverse backgrounds, indigenous backgrounds, and families with carers who have experienced school failure themselves, would all be disadvantaged by such intake systems’ with many children therefore failing to access required developmental services.

Although anecdotal reports have suggested that the quality of the information collected during clinical intake may be enhanced through reference to the pre-intake BIQ, any decision to continue using a BIQ prior to clinical intake should be carefully considered. Inclusion of a pre-intake BIQ as part of the usual clinical intake process on either a compulsory or non-compulsory basis must be supported by evidence of the value of this approach for the majority of families referred. Further investigation of the impact of including a pre-intake BIQ on the quality of the clinical intake consultation may be warranted (Girle, 2010).

In line with these conclusions, the evaluation report for the DMOC trial has recommended that, in order to reduce barriers to access at initial point of contact, Queensland Health CDS discontinue the use of pre-intake BIQs where currently applicable. This refers to only those background questionnaires collecting previous medical history and current parental concerns and does not refer to questionnaires distributed to parents and/or teachers as part of the assessment process—e.g. Conners Rating Scales or Child Behaviour Checklist (CBCL).

## 6. Change management

The Queensland Government Change Management Best Practices Guide (2009) describes the factors common to success in managing organisational change as follows:

- **Planning**—developing and documenting the objectives to be achieved by the change and the means to achieve it.
- **Defined governance**—establishing appropriate organisational structures, roles, and responsibilities for the change that engage stakeholders and support the change effort.
- **Committed leadership**—ongoing commitment at the top and across the organisation to guide organisational behaviour, and lead by example. Identify and establish change champions to provide the necessary support to staff in the planning and implementation of the change.
- **Informed stakeholders**—encouraging stakeholder participation and commitment to the change, by employing open and consultative communication approaches to create awareness and understanding of the change throughout the organisation.
- **Aligned workforce**—identifying the human impacts of the change, and developing plans to align the workforce to support the changing organisation.

The extent to which each of these five factors is exhibited in successful change initiatives will vary depending on the nature of the change involved.

Key elements in supporting employees through change include:

- identifying change champions
- consulting with employees
- providing maximum stability during the planning and implementation phases
- analysing the extent of the impact of change on people and roles
- designing new or varied jobs for the work unit
- modelling current skills of employees in the work unit to new jobs
- designing a process to match employees to different jobs and roles
- providing training for employees to meet the requirements of new roles
- designing a process for selection to available positions within the work unit.

For further information, please click on the following links:

Queensland Government 2009, Change Management Best Practices Guide: Five (5) key factors common to success in managing organisational change, [psc.qld.gov.au/library/document/catalogue/organisational-management/change-management-best-practice-guide.pdf](http://psc.qld.gov.au/library/document/catalogue/organisational-management/change-management-best-practice-guide.pdf)

Queensland Health 2009, Organisational Change Centre of Excellence, [qheps.health.qld.gov.au/peopleandculture/man\\_org\\_change/home.htm](http://qheps.health.qld.gov.au/peopleandculture/man_org_change/home.htm)

Queensland Health Clinician Development Education Service 2009, Fundamentals of Managing Change, [cdes.learning.medeserv.com.au/products/HI4682/HI4682\\_brochure.cfm](http://cdes.learning.medeserv.com.au/products/HI4682/HI4682_brochure.cfm)

The Audit Report (as distinct from the evaluation) found that there appeared to be weaknesses in some areas of the trial including:

- application of consistent processes, forms and data collection systems
- enrolment of staff in some locations in an effective change management approach
- provision of training and other professional in-service activities such as professional supervision and peer networking to reflect on professional practice in a structured manner.

The auditor speculated that these areas of oversight had contributed to creating a sense of dissatisfaction among some clinicians. However, it was concluded that the benefits achieved through the trial clearly outweighed the difficulties encountered. In a proactive approach, these difficulties were recognised through the evaluation and addressed in the recommendations of the evaluation report.

### Key lessons

- Change of this magnitude inevitably increases uncertainty amongst staff and stakeholders alike and as a result, services need to develop robust systems for ‘feeding back’, learning lessons and adapting the approach while maintaining the overall direction. This feedback and learning needs to be service-wide and needs to involve the customer, staff members and partner organisations (NHS, 2005).
- Adopting a new model of care has huge implications for clients, staff, stakeholders and the community and involves an inordinate amount of work. Many of the essential tasks are often undertaken by the same core group of individuals but a change management process of this magnitude requires carriage by the whole team.

## 6.1 Planning

A good change planning process involves:

- setting a clear vision for the change which is aligned with the service’s vision and mission
- documenting the case for change which includes outlining:
  - the drivers for change
  - what outcomes and objectives the change is seeking to achieve
  - how the change will benefit consumers, clinicians, stakeholders and the service overall
- developing the change plan (Queensland Government, 2009).

Strong governance and associated reporting arrangements need to be established from the outset to drive and monitor change. Establishment of a steering committee or reference group will provide oversight for directing and guiding the change process. There should be clearly defined terms of reference (TOR) for this collaborative forum including its decision-making jurisdiction and reporting requirements. Please refer to the following link for a Queensland Government TOR template:

[qheps.health.qld.gov.au/capital\\_works/ppas/docs/meetings/tor\\_temp\\_qg.dot](http://qheps.health.qld.gov.au/capital_works/ppas/docs/meetings/tor_temp_qg.dot)



This group needs to meet regularly throughout both the planning and implementation phases (more frequently during planning and the early phases of implementation). Agenda and minutes should be distributed prior to/and following meetings as appropriate. Strong clinical leadership together with commitment from individual change agents (champions) at the service level is essential.

Extensive consultation is mandatory in order to communicate the case for change and develop the change plan (as outlined above). Consultation may be undertaken using a variety of approaches including forums, workshops, small working groups and focus groups that involve:

- clinicians
- consumers
- stakeholders e.g. referral officers and other agencies likely to be impacted by the service redesign including other Queensland Health services e.g. Community Child Health and Child, Youth Mental Health Services (CYMHS); government e.g. Department of Education and Training (DET), Department of Communities—Disability Services (DSQ); and non-government and private providers e.g. GPs
- providers of support services e.g. Health Information Management Services and AOs. Where appropriate, involve the relevant local work unit during the planning phase to consider potential modifications to usual practice.

Planning documents need to outline the key deliverables (outcomes or key performance indicators) which should be linked to evaluation (where appropriate). Allow adequate time to receive feedback following distribution of draft planning documents.

Prior to the implementation phase, take the time to map the client's journey through your service in order to collect a 'snapshot' of service activity data. This will provide you with a pre-implementation baseline against which you can compare post-implementation outcomes.

Allocate a period not less than six months prior to the proposed implementation date (longer if possible) for the planning phase. Ensure that any new resources are developed during this time, such as implementation guidelines (including business process redesign for existing

information systems; presentations for HES; intake forms, etc.) and that any necessary in-service and training (e.g. CIO, data entry officers) has been undertaken prior to implementation.

Planning for certain elements of the proposed DMOC warrants additional discussion:

### Multidisciplinary assessment and feedback

- Consider timetabling requirements for coordinated multidisciplinary team assessment with feedback to families and school, kindergarten, childcare (as appropriate). This can be particularly challenging with part-time and sessional clinicians. Blocks of time (typically between four to eight consecutive weeks) need to be quarantined in advance for assessments, clinical discussion, feedback and goal-setting sessions and school/other agency visits (where appropriate). Electronic (e.g. GroupWise) diaries may prove useful here particularly where there is no other information systems (e.g. CHIMS) available. Allocation of specific appointments can then occur at case discussion.

### Goal-setting

- Recent research indicates that allied health clinicians have difficulty articulating client needs and priorities into specific and measurable goals (Marsland & Bowman, 2010). Pre-implementation training on goal-setting as a team may be a useful undertaking in order to ensure goals are set efficiently and consistently. This may also include training on family-centred practice to ensure the child and family are always held at the heart of the goal-setting process.
- Consider the introduction of SMART goals to ensure a clear and consistent format for goal-setting. The SMART tool can be useful to give a clear direction and expectations for all clinicians and families. SMART goals follow the following format:

- **Specific**—including the who, what, when, where and why of the goal.
- **Measurable**—make sure the goal can be measured.
- **Attainable**—ensure the goal is within reach and meaningful to the child and family.
- **Realistic**—ensure the child and family are willing and able to work toward the goal.
- **Timely**—ensure the goal has a specific time frame.

Further information on setting SMART goals can be found at the following link:

[getorganizedwizad.com/articles/how-to-set-smart-goals](http://getorganizedwizad.com/articles/how-to-set-smart-goals)





## Collaborative team reports

- According to Johnston and Colley (2009) adopting an integrated assessment approach reduces overlap and improves the comprehensiveness of assessment. Results can then be amalgamated into one team report with integrated recommendations. It is also worth considering the following guiding principles when compiling collaborative team reports. The case coordinator (or other designated clinician) assumes responsibility for adding the demographic and background information (e.g. birth history and family history) to the report to:
  - avoid duplication
  - address the concerns/questions raised by family
  - the family is the target audience therefore minimise the use of medical jargon
  - have a strengths focus
  - summarise assessment findings in the body of the report with more specific assessment results included in the appendices
  - recommendations are integrated to avoid the provision of contradicting advice
  - timely response (suggested two weeks from date of feedback session)
  - offer the family the opportunity to discuss the report and its recommended management plan as required.

A number of teams raised concerns during the trial about the time commitment involved in integrated team reports particularly relating to integrated recommendations. Metro South and Gold Coast services have convened a collaborative Report Writing Working Group to further progress this issue.

## Health education sessions

- Booking the resources necessary for conducting HES e.g. group rooms, laptops, data projectors, etc. can prove difficult for some services. Schedule your sessions well ahead of their starting date to ensure the requisite resources are available when needed.
- Although there was no expectation during the trial that participating services would offer HES outside business hours, feedback received from families who were either unable to attend or failed to attend scheduled sessions, demonstrated that inability to access childcare (particularly for sick children) and work commitments were a significant barrier to attendance. Therefore, where there is an identified need and the arrangement is convenient for both the service and presenter/s, consideration should be given



to offering sessions out of hours (e.g. early evening or Saturday mornings).

- It would also be worth investigating the provision of these sessions in more family-friendly venues within their communities (i.e. soft entry points that families are already likely to attend including libraries, immunisation centres, child health clinics, day-care centres, kindergartens, etc). There is also the potential to partner across Clinical Services Capability Framework (CSCF) Level 1–3\* services (e.g. community child health, other community and non-government organisations such as Benevolent Society, Smith Family or Spiritus) to provide generic parent education to children with non-complex developmental issues and their families.

*\*For more information on the CSCF Levels please refer to the following link: [qheps.health.qld.gov.au/pcb/docs/cscf\\_v3/10\\_childmedical.pdf](http://qheps.health.qld.gov.au/pcb/docs/cscf_v3/10_childmedical.pdf)*

## Key lessons

- Ensure adequate time for planning prior to implementation to allow for recruitment, local 'buy-in', change management (particularly the recruitment of local change champions), education and training, local network building (allowing adequate time to advise stakeholders of changes to service delivery), development of local resources, etc. There is no doubt that those services that involve their team members in planning for change from the outset are more successful in fostering clinician engagement. In other words 'People will live what they help create' (Anon).
- Include provision of a significant lead-in period to allow/facilitate a culture of contemporary health practice in child development. Consideration must be given to the adaptability of staff to change and the facilitation of strong local leadership and local champions to support change management.
- Develop implementation guidelines and protocols prior to implementation. It is vital to have clearly defined and articulated roles, responsibilities and obligations for all team members under the proposed new model including those that relate to expectations regarding participation in the new model, ongoing quality improvement and application of documentation.



In some instances, resources were developed (e.g. Information flyers alerting stakeholders and families to the imminent changes to services) but under utilised.

- Establish a robust communication plan/strategy to ensure all concerned are informed of proposed changes and have a clear understanding of their obligations.
- Ensure data collection systems are as standardised as possible to minimise user error and reduce inconsistencies with local data entry. Ensure team members responsible for data entry have the appropriate training and support.

## 6.2 Communication

The steering committee or reference group in association with the team leader/service manager (however titled) needs to develop a communication and marketing strategy that identifies the key communication activities that will be used to raise awareness of the change process and to educate and engage key stakeholders both internal and external to Queensland Health to ensure their ongoing support. The communication strategy will usually:

- provide a list of key internal and external stakeholders:
  - ensuring stakeholders are aware of the implementation and understand the key impacts, benefits and outcomes
  - gaining and maintaining the support of key Queensland Health stakeholders and decision-makers during the implementation
  - encouraging key Queensland Health stakeholders to become champions and advocates for communicating key messages about the implementation
  - ensuring project staff and stakeholders are aware of marketing initiatives and training events
  - encouraging effective communication and feedback from stakeholders.
- provide a communication action plan based on key implementation milestones and organisational change management, training and technical activities:
  - increasing awareness of the timeframes, processes and milestones of the change process
- document high level corporate messages

- document communication roles, responsibilities, approvals and feedback processes
- document techniques for evaluation – wherever possible develop the evaluation plan prior to implementation.

Establishing a robust communication strategy ensures team members are informed of proposed changes and have a clear understanding of their revised obligations and responsibilities (where appropriate). Once again a variety of approaches can be used to communicate with team members (e.g. information flyers, slideshow presentations, workshops, forums, working groups) prior to implementation and a register of concerns e.g. issues log (Survey Monkey) or frequently asked questions and regular update communiqués can be used during implementation. A generic issues log has been designed in Survey Monkey and included in Appendix 6 and an example of a regular implementation update is included in Appendix 7.

It is important to respond promptly to any concerns raised by clinicians particularly during the implementation phase as rumour and miscommunication can be quite undermining to the change process if allowed to remain unchecked. An online survey tool (e.g. Survey Monkey) provides an opportunity for clinicians who may prefer to provide their feedback anonymously.

Customers (clients/families) need to be made aware of the imminent changes to service delivery well in advance of the implementation date and posters (displayed in the service's waiting room or community child health centres, for example) service brochures (distributed to referring stakeholders) and letters are valuable here. Stakeholders both internal and external to Queensland Health (e.g. GPs, guidance officers, CH/SHN, local hospitals, CYMHS, etc.) must also be informed of the proposed changes and the potential impacts on their own services. While a face-to-face presentation is the most effective way of communicating proposed changes to service delivery, information flyers, service brochures and letters may all be used successfully.

## 6.3 Data collection and reporting

There is an unquestionable need for Queensland Health CDS to start collecting and reporting on consistent client and service information statewide in order to facilitate a more robust approach to demand management. To that end, the database (originally developed to facilitate

evaluation during the DMOC trial) has been further refined and expanded to form the basis of a statewide CDS minimum dataset\*. Data elements have been included in order to collect information relating to:

- client and family demographics
- referral details
- intake and eligibility
- allocation (designated clinical care pathways)
- diagnosis (where appropriate) and discharge.

*\*Acknowledge that this forms a starting point to allow consistent collection of uniform data; but does not represent a comprehensive clinical dataset*

The Client Identification Data Set Specification (CI DSS) has been endorsed as the Queensland Health standard for identifying clients. The CI DSS is one of the key priorities of the eHealth Foundation (Information) Implementation Team (eFIT) and is to be adopted when collecting and recording key client demographic data at the point of registration. Please refer to the following link for more information on CI DSS: [qhps.health.qld.gov.au/clinical\\_info\\_mgt/html/cidss.htm](http://qhps.health.qld.gov.au/clinical_info_mgt/html/cidss.htm)

The statewide CDS Data Collection Tool has been developed in accordance with the CI DSS and contains a minimum activity-based dataset aimed at introducing uniformity to data collected by Queensland Health CDS.

Data will be entered initially into a form (with mandatory and optional fields) that will automatically populate the database (Excel spreadsheet). Mandatory formatting and drop-down boxes will help minimise user error. Please refer to Appendix 8 for further details.

Adoption of a new data collection system is not without its own challenges particularly for those services/teams that already collect client/referral information using one of Queensland Health's existing information systems (e.g. HBCIS, ASIM, and PI5) or alternatively, their own electronic and/or manual spreadsheet/s. The question of who is responsible for data entry needs to be carefully considered particularly where there is no dedicated administrative support; however completion of the database must be a team priority.

Training in the correct use of the database will be essential to help minimise weaknesses in the data collection system (e.g. incorrect or incomplete data entry). Further details for reporting, collation and interpretation of the collected data are yet to be determined.

As mentioned previously, it is important to get a baseline of service activity (e.g. numbers of referrals, occasions of service, etc.) prior to

implementation for use as a comparator pre- and post-implementation.

## 6.4 Monitoring and evaluation

A number of resources were developed to assist with evaluation of HES, client satisfaction and staff satisfaction (Survey Monkey, issues log).

### • Pre- and post-attendance at Health Education Sessions

The surveys were adapted from a pre- and post-evaluation developed at the Queensland Centre for Mental Health Learning relating to the knowledge/learning acquired when undertaking training in the administration of the Mental State Examination (2007). The adapted evaluation can be used to measure success in the transfer of information/knowledge gained and skills/strategies acquired by parents/carers in managing their child's developmental issue/s.

Completion of the survey should be voluntary. In order to ensure confidentiality, a unique identifying code is used to allow matching of pre- and post-session responses. Additionally, a scripted instruction sheet was developed for clinicians to use when requesting families complete the evaluation forms. Refer to Appendix 9 for additional details.

### • Pre- and post-implementation client satisfaction survey

The Measure of Processes of Care (MPOC) is a self-report measure of parent's perceptions of the extent to which specific behaviours of health care professionals occur. MPOC was created originally for research to examine the way in which care is delivered (the process of care) and the impact that this service delivery has on children with disabilities and their families. Both the MPOC and the shorter and improved version MPOC-20 demonstrate good internal consistency, reliability, and validity and offer users a measurement option that is useful for program evaluation and quality assurance activities as well as for research purposes (King et al, 2004). The pre- and post-trial client satisfaction questionnaires were adapted from the MPOC and MPOC-20.

Completion of the questionnaire should be voluntary, and clear



instructions including a sample question are provided. Additionally, a scripted instruction sheet was developed for clinicians to use when requesting families complete the questionnaire. Refer to Appendix 10 for additional details.

- **Pre-implementation staff satisfaction survey**
- **Post-implementation staff satisfaction survey**
- **Post-implementation stakeholder satisfaction survey**

These surveys were all created using Survey Monkey and the results can be captured in such a way as to ensure the anonymity of respondents. Wherever appropriate, include the same questions pre- and post-implementation to inform the subsequent evaluation. Where possible and practical, examples of these surveys have been de-identified for application by all Queensland Health CDS. Additionally, a cover letter has been developed to recruit stakeholders to the evaluation. Please refer to Appendices 11 and 12 for examples.

### Key lessons

- Engaging team members in distributing evaluation forms and/or questionnaires proved challenging during the DMOC trial. A commitment to continuous quality improvement needs to be embedded from the outset in the roles and responsibilities for team members and articulated in the implementation guidelines.
- Clinician participation in post-trial evaluation processes was significantly reduced when compared to the pre-trial period. It is important to maintain clinician engagement in the evaluation process (e.g. regular communiqués) and as previously mentioned, to embed involvement in the evaluation process in the implementation guidelines.
- Families should be recruited when they attend the centre, preferably in the waiting area before scheduled appointments. Reliance on the return by post of mailed surveys is most unreliable even with the inclusion of stamped and addressed envelopes.
- Sufficient time should be allowed for to follow-up with reminder letters, emails or phone calls when potential respondents fail to meet the nominated deadline for response.

## 6.5 Documentation

It is important to recognise that the protocols and documentation developed for implementation of a new model of care evolve in a process of continuous quality improvement. It is therefore

essential to ensure that all concerned are apprised of any changes as they occur and that documents have the appropriate version control. Services within the same district might consider the use of a ‘shared’ folder (Novell) to facilitate this.

### Change-over documentation

There are a variety of approaches available for alerting clinicians, stakeholders (both internal and external to Queensland Health) and families about the imminent changes to service delivery including letters, flyers, posters, brochures, emails, etc. These should be outlined in the team’s pre-implementation communication strategy. Examples of information flyers developed for both parents/carers and stakeholders are provided— Appendix 13.

### Resource manual

All Queensland Health CDS should develop a resource manual containing both generic and service-specific information for distribution to referring stakeholders and those families determined as not for service (NFS). Generic information might include details on:

- Chronic Disease Individual Allied Health Services under Medicare (previously known as Enhanced Primary Care funding)
- Better access to Allied Mental Health Services through the Medicare Benefits Schedule (MBS) program
- Aboriginal and Torres Strait Islander Allied Health Services
- A Better Start for Children with a Disability —Early Intervention and other services for children with disabilities.

Service specific information might include (but should not be limited to) contact details for:

- private service providers
- primary healthcare providers e.g. GPs, CH/SHN
- other Queensland Health agencies e.g. CYMHS
- other government and non-government agencies.

Please refer to Appendix 14 for an example of a generic Resource Manual.

### Implementation guidelines

It is crucial to have an implementation plan that includes all relevant guidelines and protocols developed well in advance of the start date. Insufficient pre-implementation planning may lead to confusion and uncertainty for some staff members. As a consequence, inadequate preparation can result in increasing levels of stress and a resultant decrease in staff satisfaction.

It is recommended that at a minimum, implementation guidelines should include:

- clearly articulated characteristics of the new model with particular reference to:
  - proposed changes to eligibility criteria and referral pathways
  - descriptions of clinical care pathways
  - proposed changes in roles and responsibilities for both clinical and administrative staff
- non-attendance guidelines
- evaluation procedures including obligations for clinical and administrative staff
- clinical documentation, sample forms and letters
- protocols (business rules) for any existing information systems that may be impacted by the new model and any new data collection system introduced.

### Referral and intake

A number of resources have been developed during this and other projects that help inform the clinical decision-making process required during intake particularly regarding the determination of clinical complexity:

- Referral guide
  - A generic referral guide has been developed for referrals to AH clinicians who have a developmental caseload within a paediatric AH service—Appendix 15.
- Intake proforma
  - Please refer to Appendix 16 for an example of a generic intake proforma.
- Screening tools/checklists
  - The use of consistent and/or complementary screening tools/development checklists across the primary health care sector and CDS is highly recommended. For example, clinicians may use the Ages and Stages Questionnaire 3rd Edition\* (ASQ-3) or any other screening tool relevant to age. Please refer to the following websites for additional information on the ASQ-3: [brookespublishing.com/tools/asq/index.htm](http://brookespublishing.com/tools/asq/index.htm) [pearsonpsychcorp.com.au/productdetails/362/1/49](http://pearsonpsychcorp.com.au/productdetails/362/1/49)

*\*ASQ-3 is a validated parent-completed questionnaire with high reliability, internal consistency, sensitivity (86 per cent) and specificity (85 per cent).*

  - The Red Flag Resource—Early Intervention Guide for Children 0–5 years developed by the Child Development Program (Children’s Health Services) in conjunction with GP partners is available from: [qhps.health.qld.gov.au/rch/cchs/Resources/red\\_flag.pdf](http://qhps.health.qld.gov.au/rch/cchs/Resources/red_flag.pdf) and can be displayed in waiting rooms of GPs, childcares, kindergartens, community child health centres and other venues that parents are likely to attend.

- Complexity matrix
 

This model developed by Bernie (2008) helps define the complexity and risk factors of children with developmental delays and their families based not only on the number of developmental domains involved, but also on family and environmental factors (attributes). Please refer to Appendix 17 for additional information.

### Clinical documentation

- Case discussion/allocation form
  - Completed during the formal multidisciplinary discussion that occurs following intake and records the disciplines and programs to which the child/family is allocated.
- Clinical discussion (case conference) form
  - Completed during the formal multidisciplinary discussion that occurs following assessment and may also be used for review discussions.
- Feedback form
  - Completed during the feedback session conducted with both clinicians and family members.
- Goal-setting form
  - Completed during the goal-setting session conducted with both clinicians and family members.
- Collaborative team report proforma
  - Applies to multidisciplinary assessment of clients managed through the MEIT and MAIP pathways.

Generic examples of these forms are provided in Appendix 18.

### Non-attendance guideline

The service’s implementation guidelines should include a pre-determined response to clients/families who fail to attend scheduled appointments. Please refer to the Queensland Health Outpatient Services Implementation Standard available on [qhps.health.qld.gov.au/policy/docs/imp/qh-imp-300-1.pdf](http://qhps.health.qld.gov.au/policy/docs/imp/qh-imp-300-1.pdf) for more information.

This guideline should be consistently applied although any unforeseen impediments to a family’s attendance must be evaluated individually and respectfully.





Please note that clients and their parents/ carers must have prior notification of the policy therefore, the procedure for managing families who do/did not attend (DNA) a scheduled appointment should be:

- displayed in a public area of the facility
- explained by the CIO or administration staff when a family first makes contact with the centre
- included in appointment letters and/or written material provided to clients. Where appropriate, the relevant section about DNA should be specifically brought to the attention of the client or carer.

For an example of a generic non-attendance guideline, please refer to Appendix 19.

### Correspondence

- not for service (Ineligible) letter to parent/carer
- not for service (Ineligible) letter to GP or other referral agent or officer
- fail to attend (FTA)/DNA letters
  - Please refer to Attachment 3—Approved Outpatient Services Letter Suite (Queensland Health Outpatient Services Implementation Standard) available on [qheps.health.qld.gov.au/policy/docs/imp/300-att-3.pdf](http://qheps.health.qld.gov.au/policy/docs/imp/300-att-3.pdf) for more information
- appointment letters.

Generic examples of correspondence are included in Appendix 20.



### Description of Health Education Sessions

CDABS originally developed a number of education sessions for parents as part of their service redesign and these were later adapted for use by the Metro South HSD and AHPS. Both CDABS and Metro South services applied their education sessions as a mandatory pre-requisite to engage further with the team for appropriate clients/families\*, while the AHPS sessions were presented as an integral part of the therapy group aimed at providing the following messages:

- an overview of the developmental stage of their child, now and ‘what to expect next’
- an outline of expectations of them within the group environment and home follow through activities.

\*Excludes culturally and linguistically diverse (CALD) families, those families unlikely to benefit from/cope with group-based education and referrals for certain conditions.

Experiences in both Gold Coast and Metro South services confirmed that sessions presented by speech pathology (SP)—e.g. Toddler Talk and Kids’ Talk proved most popular and were most consistently attended. Sessions on toddler and pre-school behaviour conducted by CDABS psychology were also reasonably attended. However, those sessions offered by occupational therapy (OT) and physiotherapy (PT) in a group format were less successful. As an alternative, some PT and OT clinicians offered ‘individual’ education sessions wherein a screening assessment of the child was conducted. Titles of the education sessions developed are listed in Table 5.

**Table 5: Education sessions for parents/carers**

Talk	Discipline	Target Audience
Toddler Talk	SP	0–2½ years
Kids’ Talk		2½–4 years
Sitters, Crawlers and Walkers	PT	0–2 years
Runners and Jumpers		2–4 years
Skills for Hands	OT	1–4 years
Sensational Youngsters		0–4 years
Toddler/Preschool Behaviour Management	Psychology	1½–4 years
Autism Spectrum Disorders (ASD): Information and Behaviour Management		0–8 years
Building Resilience and Self Esteem		
Managing Children’s Anxiety		

For more information on the education sessions developed please refer to Appendix 21. The slide shows for two of the most popular talks (Toddler Talk and Kids’ Talk) have been converted to PDF and included in Appendix 22.

It is acknowledged that a further substantial body of work needs to be undertaken around the local provision of education sessions for parents/carers including a review of content (bearing in mind the evidence base and target audience); timing of the sessions within the client’s journey through the service; and more family-friendly locations and scheduling.

Furthermore, in order to improve universal access to generic information on child-development related topics for families of children with non-complex developmental issues, consideration should also be given to how these sessions are delivered, who is most appropriately placed to deliver them (e.g. partnerships with CSCF Levels 1–3), where is the most successful place to deliver them and at what time.

## 6.6 Training and support

A number of training resources are already available both within and external to Queensland Health including the following:

### Family Partnerships Model training

- The Family Partnerships Model was developed by Professor Hilton Davis and colleagues from the Centre for Parent and Child Support U.K: [cpcs.org.uk](http://cpcs.org.uk)
- The Family Partnerships Model is supported by its demonstrated usefulness to practitioners and by evidence from research studies, which strongly suggests that the Family Partnerships Training enables professionals to feel more confident and competent in relating to parents. Studies including two randomised controlled trials have also shown that the psychosocial functioning of both parents and children experiencing childhood disability and mental health problems improves when they work with practitioners trained in the Family Partnerships approach. (Centre for Community Child Health, 2011 [rch.org.au/ccch/profdev.cfm?doc\\_id=10509](http://rch.org.au/ccch/profdev.cfm?doc_id=10509))
- Family Partnerships Model training is recommended for health care professionals working with parents (Queensland Health Child and Youth Health Practice Manual, 2007). Check with the Community Child Health Service within your district for training opportunities.
- Additional information is available from Family Partnership Training Australia at the following website: [fpta.org.au](http://fpta.org.au)

### Lean thinking training

- Further information is available from Lean Australia: [leanaust.com/index.htm](http://leanaust.com/index.htm)

### Training and learning resources

- The Allied Health Clinical Education and Training Unit (AHCETU) has developed a number of self-directed Learning Modules and Key Concept Learning Resources on a variety of topics of relevance to OTs which have application to all other AH disciplines involved in child development practice e.g.:
  - interdisciplinary and transdisciplinary team functioning
  - family-centred practice (from both a customer and service delivery perspective)
  - collaborative report writing
  - goal-setting and feedback with families.

For further information please access the following link: [qheps.health.qld.gov.au/cetu/html/ahoccther/lr.htm](http://qheps.health.qld.gov.au/cetu/html/ahoccther/lr.htm)

- Communication and teamwork
  - e.g. Workplace communication module available at: [qheps.health.qld.gov.au/learning\\_dev/html/toolkits.htm](http://qheps.health.qld.gov.au/learning_dev/html/toolkits.htm)
  - AH New Starter Framework [qheps.health.qld.gov.au/cunningham-centre/html/ah-nsf.htm](http://qheps.health.qld.gov.au/cunningham-centre/html/ah-nsf.htm)

### Child Development Connection

- The Child Development Connection provides regular video-conferences and training on topics of interest to clinicians working in child development. More information is available from: [child\\_development\\_connection@health.qld.gov.au](mailto:child_development_connection@health.qld.gov.au)

## 7. Other useful resources, tools and links

1. **Queensland Health People and Culture Network** have established a Special Interest Group (SIG) for organisational change in order to provide a forum for consultation, sharing or learning and issues, professional development and promotion of best practice in change. Membership of the Change SIG is open to all Queensland Health employees. More information can be found at the following sites: [qheps.health.qld.gov.au/peopleandculture/man\\_org\\_change/html/learning.htm#sig](http://qheps.health.qld.gov.au/peopleandculture/man_org_change/html/learning.htm#sig) [qheps.health.qld.gov.au/peopleandculture/man\\_org\\_change/home.htm](http://qheps.health.qld.gov.au/peopleandculture/man_org_change/home.htm)
2. **Clinical Capabilities for Health Professionals working in Child Development—infants to adolescents**

This document provides a broad capability framework for identifying common knowledge and skills required for the delivery of services to children with developmental difficulties and their families attending Queensland Health CDS.

These practice standards (capabilities) developed for all clinicians working with children with developmental difficulties and their families (i.e. AH, medical and nursing) are summarised in Table 6 on the following page.

The Queensland Health Clinical Capabilities for Health Professionals working in Child Development—infants to adolescents (2011) should be available shortly on QHEPS.

**Table 6: Units and elements of capability for health professionals working in child development (Child Development Program, 2011)**

Units of capability	Elements of capability
Epidemiology of developmental difficulties	<ul style="list-style-type: none"> <li>• Understanding of the prevalence and co-morbidity of developmental difficulties in children</li> <li>• Understanding of the life course of developmental difficulties in children</li> <li>• Understanding of risk, causal and protective factors impacting on children with developmental difficulties.</li> </ul>
Assessment and diagnostic process in child development	<ul style="list-style-type: none"> <li>• Understanding of the purpose and practice of assessment within the overall management process</li> <li>• Diagnostic formulation</li> <li>• Understanding of diagnostic categories and criteria in developmental difficulties</li> <li>• Working collaboratively with other health and education professionals in the area of child development.</li> </ul>
Family and child-centred practice in child development	<ul style="list-style-type: none"> <li>• Engaging with the child through stages of assessment and intervention</li> <li>• Engaging with parents as partners</li> <li>• Providing feedback, setting goals and planning ongoing management</li> <li>• Providing collaboration and partnership with community stakeholders.</li> </ul>
Service development, evidence-informed practice and quality improvement	<ul style="list-style-type: none"> <li>• Consistent philosophy guiding service provision to children with developmental difficulties and their families</li> <li>• Commitment to ongoing learning including personal professional development activities and continued support of other health professionals and students</li> <li>• Evidence-informed clinical practice—keeping up with best research evidence and implementing within clinical practice.</li> </ul>

**3. Guidelines for speech pathology practice in child development services:**

[qheps.health.qld.gov.au/ahwac/docs/Re-Entry/child-dev/cdp\\_guidelines.pdf](http://qheps.health.qld.gov.au/ahwac/docs/Re-Entry/child-dev/cdp_guidelines.pdf)

**4. Prioritisation guidelines for speech pathology practice in child development services:**

[qheps.health.qld.gov.au/ahwac/docs/Re-Entry/child-dev/cdp\\_priorities\\_spp.pdf](http://qheps.health.qld.gov.au/ahwac/docs/Re-Entry/child-dev/cdp_priorities_spp.pdf)

**5. Guidelines for occupational therapy practice in child development services.**

Available shortly on QHEPS

**6. Prioritisation guidelines for occupational therapy practice in child development services.**

Available shortly on QHEPS

**7. Discipline-specific capability frameworks:**

Please refer to the AHCETU website: [qheps.health.qld.gov.au/cetu](http://qheps.health.qld.gov.au/cetu) for additional information.

**8. Complaints process**

Complaints from clients will need to be processed via the district complaints protocol. Please refer to your team/service manager for more information or to the following link: [qheps.health.qld.gov.au/patientsafety/prime/cf/cf\\_forms.htm](http://qheps.health.qld.gov.au/patientsafety/prime/cf/cf_forms.htm)

**9. Survey Monkey**

Survey Monkey is a popular survey software tool. Step-by-step instructions allow you to design (create), collect and analyse your survey data in a user friendly format. Please refer to [surveymonkey.com](http://surveymonkey.com) for additional information.

**10. Telehealth**

Consider the use of teleconference and video-conference in order to facilitate team meetings (where clinicians are spread across multiple sites).

**11. SMS via email**

SMS appointment reminders to clients can be sent via SMS from your PC via email (e.g. GroupWise). You can send an SMS of up to 100 characters. This can significantly reduce the number of DNA appointments and is an efficient way to manage individual and group appointments.

In the 'To' line, type in the mobile phone number@smsmessages.health.qld.gov.au  
E.g. 0400123456@smsmessages.health.qld.gov.au

Type your message into the 'Subject' line only. Leave the message area blank as this will not be transmitted.

## 12. Generic email addresses

Establishing a generic email address for the CIO has a number of benefits:

- a. helps to separate out emails specifically concerned with referrals for child development and paediatric therapy services from other more general or personal emails
- b. ensures that all referrals are processed promptly rather than being delayed due to an unexpected absence by the usual staff member
- c. allows reports or other information to be forwarded to the CIO electronically.

In order to create a generic email address, you will need to access Helpdesk Support (via Self Service Centre or 1800 198 175) and submit a Resource Account request for GroupWise.

## 13. Shared folder (intra-district)

Establishing a common folder that can be accessed by all CDS services/teams within a particular district facilitates sharing of resources. In order to create a shared folder, you will need to access Helpdesk Support (via Self Service Centre or 1800 198 175) and submit a New Workgroup Owner request for Novell.

## 14. ClinEdQ Portal

Developed as an initiative of the eNursing committee (Nursing and Midwifery Office, Queensland) that provides:

- a. a consistent way of accessing clinical education training information and resources
- b. improved connection and collaboration between health professionals.

Logon information and access is available on the ClinEdQ site:

[health.qld.gov.au//clinedq/html/portal.asp](http://health.qld.gov.au//clinedq/html/portal.asp)

<http://clinedqportal.health.qld.gov.au>

Username = QH\yournovellusername

Password = yournovellpassword

## 15. Wordle (Word Clouds)

[wordle.net/create](http://wordle.net/create)

## 16. Allied Health Workforce Advice and Coordination Unit (AHWACU)

[qhps.health.qld.gov.au/ahwac](http://qhps.health.qld.gov.au/ahwac)

## 17. Allied Health Clinical Education and Training Unit (AHCETU)

[qhps.health.qld.gov.au/cetu](http://qhps.health.qld.gov.au/cetu)

## 18. The Cunningham Centre

[health.qld.gov.au/cunninghamcentre](http://health.qld.gov.au/cunninghamcentre)





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