phn
BRISBANE SOUTH
An Australian Government Initiative

QUALITY IMPROVEMENT TOOLKIT
FOR GENERAL PRACTICE

Mental health

Mental health overview

MODULE

Version 1

Introduction

The Quality Improvement Toolkit

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

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

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

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

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

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

If you would like additional support in relation to quality improvement in your practice please contact Brisbane South PHN on optimalcare@bsphn.org.au

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

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

Acknowledgements

We would like to acknowledge that some material contained in this Toolkit has been extracted from organisations including the Institute for Healthcare Improvement; the Royal Australian College of General Practitioners (RACGP); the Australian Government Department of Health; Best Practice; Medical Director, CAT4; and Train IT. These organisations retain copyright over their original work and we have abided by licence terms. Referencing of material is provided throughout.

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

Brisbane South PHN, 2020

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Mental health

Mental health introduction toolkit for general practice

This toolkit is designed to assist you to review your patients who may be affected by a mental health condition. This is part of the introduction module with sub topics available. It is suggested that you work through this toolkit and then identify the sub topic to focus on.

Key topics included in this toolkit are:

- overview of mental health in the Brisbane south region
- understanding your patient mental health profile
- comparing your patient profile with other practices via Brisbane South PHN's benchmark report
- data cleansing – ensure all patients that are coded with mental health have been marked active/inactive, indication with no diagnosis
- co-morbidities
- preventative health measures including:
    - family & social history
    - blood pressure
    - weight, height & BMI
    - nutrition
    - smoking
    - alcohol status
    - physical activity
- Medicare item numbers for mental health patients including how to complete templates
- tools to assist with diagnosis (K10, depression scale etc)
- recalls/reminders
- appropriate care co-ordination in the practice (who does what)
- policy & procedures (including mental health policy strategy), anti-bullying in the workplace, support for staff when dealing with stressful situations, GP self-care
- referral pathways and support options
- resources.

Key goals/objectives for using this toolkit

This toolkit is to be used in general practice to:

- identify those patients in your practice at risk of mental illness (e.g. those with chronic disease)
- develop a register of patients with a mental health condition to facilitate better continuity of care (reminders, recalls)

- have the ability to better manage the physical health of patients with a mental health condition
- improve medication management through review against clinical guidelines (e.g. appropriate use of medications, risk management)
- identify patients eligible for mental health and other funding streams.

What is a mental illness?

About one in five Australians will experience a mental illness, and most of us will experience a mental health problem at some time in our lives.

A mental illness is a health problem that significantly affects how a person feels, thinks, behaves, and interacts with other people. It is diagnosed according to standardised criteria.

A mental health problem also interferes with how a person thinks, feels, and behaves, but to a lesser extent than a mental illness.

Mental health problems are more common and include the mental ill health that can be experienced temporarily as a reaction to the stresses of life.

Mental health problems are less severe than mental illnesses, but may develop into a mental illness if they are not effectively dealt with.

Mental illnesses cause a great deal of suffering to those experiencing them, as well as their families and friends. There are a number of risk factors relating to mental illness including:

- biological factors, such as genetics and physical illness
- lack of support network
- external factors such as job loss, relationship breakdown, family conflict, and financial and environmental stressors.

Furthermore, these problems appear to be increasing. According to the World Health Organization, depression will be one of the biggest health problems worldwide by the year 2020.[1]

Types of mental illness

Mental illnesses are of different types and degrees of severity. Some of the major types are:

- depression
- anxiety
- schizophrenia
- bipolar mood disorder
- personality disorders
- eating disorders

The most common mental illnesses are anxiety and depressive disorders.

[1] https://www1.health.gov.au/internet/publications/publishing.nsf/Content/mental-pubs-w-whatmen-toc~mental-pubs-w-whatmen-what

Treatment of mental illness

Most mental illnesses can be effectively treated. Recognising the early signs and symptoms of mental illness and accessing effective treatment early is important. The earlier treatment starts, the better the outcome.

Episodes of mental illness can come and go during different periods in people's lives. Some people experience only one episode of illness and fully recover. For others, it recurs throughout their lives.

Effective treatments can include medication, cognitive and behavioural psychological therapies, psycho-social support, avoidance of risk factors such as harmful alcohol and other drug use, and learning self-management skills.

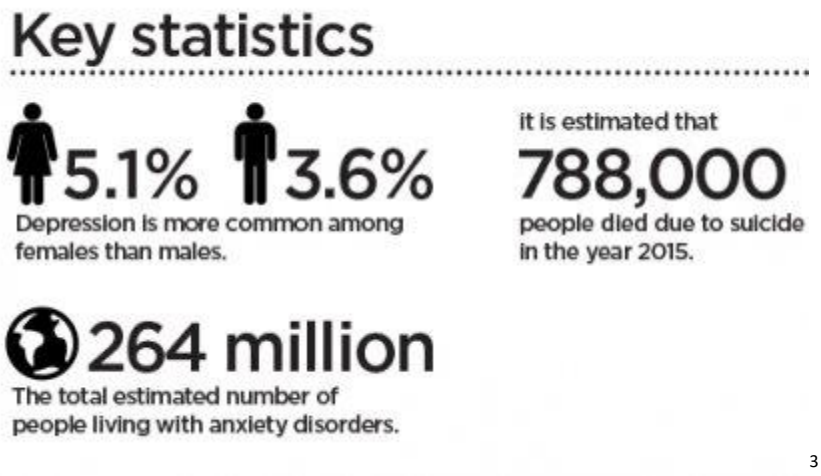
People with mental health conditions often experience a disproportionately higher burden of physical disease. Treatment options for physical help to assist with mental illness include reviewing nutrition, exercise, preventative health care (screening) and addressing risk factors such as smoking, alcohol use and drug use (prescribed and illicit).

Mental health statistics

The National Survey of Mental Health and Wellbeing: Summary of Results, 2007 demonstrates the following:

- Depression: One in seven Australians will experience depression in their lifetime. One in 16 Australians are currently experiencing depression.
- Affective disorders: Fifteen per cent of Australians aged 16 to 85 have experienced an affective disorder. This is equivalent to 2.83 million people today. In the last 12 months, 6.2% of Australians aged 16 to 85 have experienced an affective disorder. This is equivalent to 1.16 million people today.
- Anxiety: One in seven Australians are currently experiencing an anxiety condition. One quarter of Australians will experience an anxiety condition in their lifetime and 26.3% of Australians aged 16 to 85 have experienced an anxiety disorder. This is equivalent to 4.96 million people today.
- Support-seeking appears to be growing at a rapid rate, with around half of all people with a condition now getting treatment. The estimated population treatment rate for mental disorders in Australia increased from 37% in 2006–07 to 46% in 2009–10.
- Women are more likely than men to experience depression and anxiety. One in six women will experience depression in their lifetime compared with one in eight men. One in three women will experience an anxiety condition in their lifetime compared with one in five men
- One in eight Australians is currently experiencing high or very high psychological distress. In 2017-18, around one in eight (13.0% or 2.4 million) Australians aged 18 years and over experienced high or very high levels of psychological distress, an increase from 2014-15 (11.7%). Between 2014-15 and 2017-18, rates of high or very high psychological distress remained reasonably stable across most age groups, with the exception of an increase in 55-64-year-old women (from 12.3% to 16.9% respectively). [2]

[2] https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4326.0Main+Features32007?OpenDocument



[3]

Mental health in the Brisbane south region

In 2017 Brisbane South PHN commenced a planning process to create a regional mental health, suicide prevention, and alcohol and other drug strategy and roadmap for 2019-2022.

The final Brisbane South Mental Health, Suicide Prevention, and Alcohol and Other Drug (MHSPAOD) Strategy 2019-2022 and roadmap articulates a system-wide vision for future provision of services in Brisbane south, which has been developed based on information from the 2018 Needs Assessment and through extensive consultation with consumers, carers, the public sector, private and non-government service providers and primary care.

A key driver for the development of the MHSPAOD Strategy is Brisbane South PHN's remit to improve the coordination of services across the community and:

- meet the increasing needs of the Brisbane South PHN population, and in particular, support the provision of localised services that provide access to underserviced populations
- support the provision of evidence-based, appropriate and effective care
- increase accessibility and equity of service provision for the community, and in particular, support the provision of the right services, in the right location, at the right time
- improve integration and continuity of care for clients between providers and health delivery partners such as General Practitioners (GPs), not-for-profit organisations and hospital and health services
- better align with Brisbane South PHN's role as a commissioner
- drive value for money and outcomes-based results through robust agreements with service providers.

The MHSPAOD Strategy and roadmap will guide the collaborative approach to planning and service for the region, as well as the recommissioning of primary mental health, suicide prevention, and alcohol and other drug treatment services by Brisbane South PHN.[4]

[3] https://www.uq.edu.au/news/article/2017/04/uq-researchers-play-key-role-world-health-day
[4] https://bsphn.org.au/wp-content/uploads/2019/03/Brisbane-South-Mental-Health-Suicide-Prevention-and-Alcohol-and-Other-Drug-MHSPAOD-Strategy-2019-2022.pdf

Activity 1 - Understanding your patient mental health profile

Using CAT4 to identify your practice's mental health patients

There are a few searches that you can do on CAT4 to identify and manage patients with mental health conditions. Correctly identifying and coding people who have mental health conditions allows for regular monitoring and treatment optimisation and is vital for automatic software prompts, e.g. medications which may need monitoring (such as lithium) or compliance (such as depo-antipsychotic medication), or overuse/underuse of medications.

Data Review – patients with indicated mental health with no diagnosis

The 'Indicated Mental Health with no diagnosis' report will display the likelihood of a mental health condition based on a mental health medication or a mental health care plan being recorded in the patient record without a diagnosis. Any mental health diagnoses included in the existing CAT4 reports/filters is considered, regardless of whether the diagnosis is marked as active or inactive in the patient record.

- Red = likely
- Orange = possible

RED:	**ORANGE**:
Has a Mental Health Care Plan MBS item number claimed (2700, 2701, 2715, 2717 or previous 2702 or 2710)	On a mental health medication

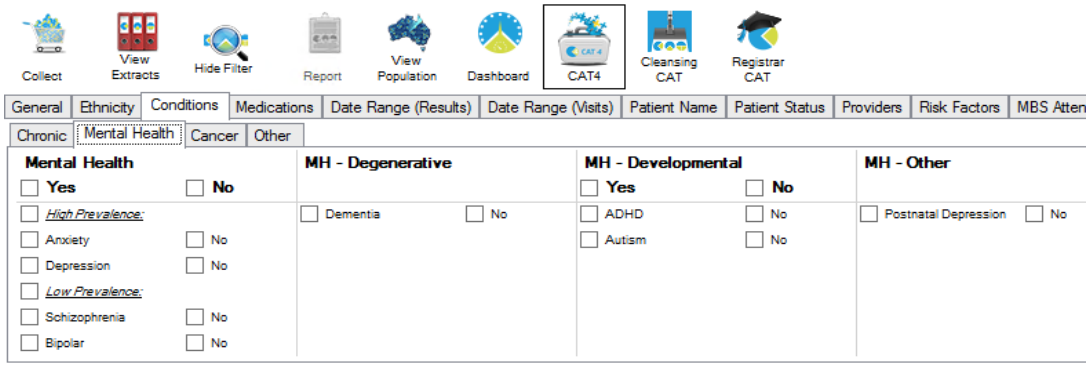
The report displays:

- MH medication
- MH MBS item numbers
- chronic disease co-morbidities/risk factors
- other MH risk factors.

Identifying patients with a mental health condition

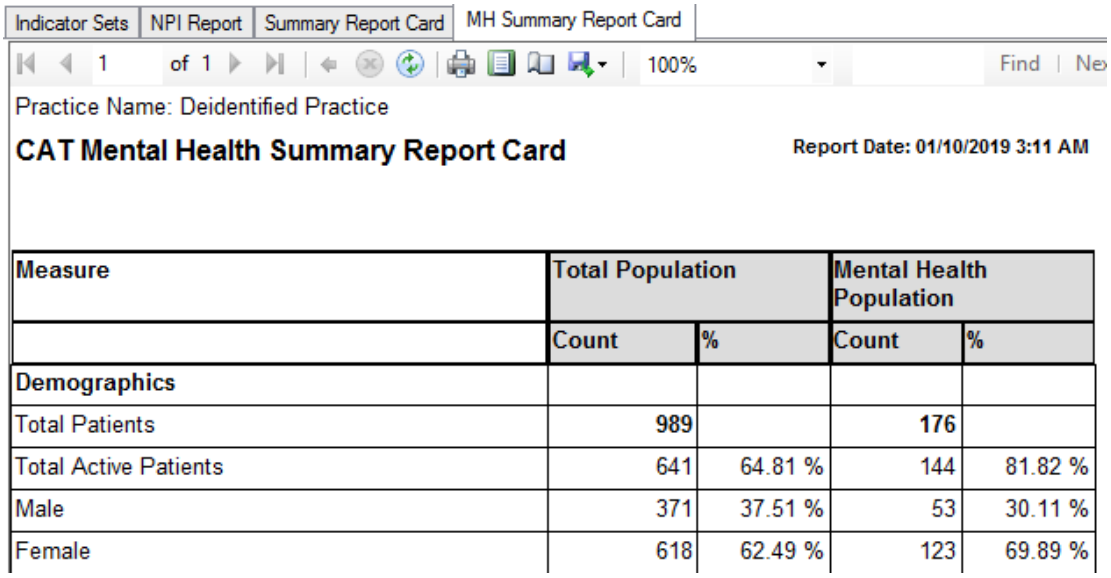
You are able to search for patients with mental health disorders under conditions. These include:

- mental health, including high prevalence (anxiety, depression), low prevalence (schizophrenia and bipolar)
- MH – degenerative, including dementia
- MH – development, including ADHD and ASD
- MH – other including depression during and after pregnancy.



Mental Health Summary Report Card

The MH Summary Report Card is available under the 'Standard Reports' tab. This report provides a snapshot of GP data relating to mental health. It is designed to encourage GPs to review and update their management strategies for patients diagnosed with mental health disorders, specifically schizophrenia, in their practices.


Indicator Sets | NPI Report | Summary Report Card | MH Summary Report Card

1 of 1 100% Find | Ne

Practice Name: Deidentified Practice

CAT Mental Health Summary Report Card

Report Date: 01/10/2019 3:11 AM

Measure	Total Population		Mental Health Population	
	Count	%	Count	%
Demographics				
Total Patients	**989**		**176**	
Total Active Patients	641	64.81 %	144	81.82 %
Male	371	37.51 %	53	30.11 %
Female	618	62.49 %	123	69.89 %

Identify all active patients with at least one chronic condition who may be eligible for a medication review

Patients with chronic conditions are often taking multiple medications and would benefit from a review of their medications. This will ensure appropriate medications are prescribed and helps to reduce side effects and other medication-related risks.

Identifying patients via risk factors

The 'Risks Factors' filter allows practices to filter for patients using the risk factors of smoking, alcohol (drinker and high risk), drug use, and obesity. The risk factors are defined as:

- smoking – daily or irregular
- alcohol – drinker: drinks alcohol
- alcohol – drinker high risk: 2 or more drinks on a regular occasion or more than 4 drinks on any occasion
- medication/drug use – coded diagnosis in patient record
- obesity – BMI of 30 or more.

Please note: select **mental health** under the **conditions** section of CAT4 to search on patients with a known mental health condition.

Identifying patients who may be eligible for a mental health treatment plan

The GP mental health treatment plan (MHTP) provides a structured framework for GPs to undertake early intervention, assessment and management of patients with mental disorders, as well as providing referral pathways to clinical psychologist and allied mental health service providers.

Please note: this report will produce a large number of patients. You may wish to filter the search by including the number of visits per year.

Identifying patients with co-morbidities

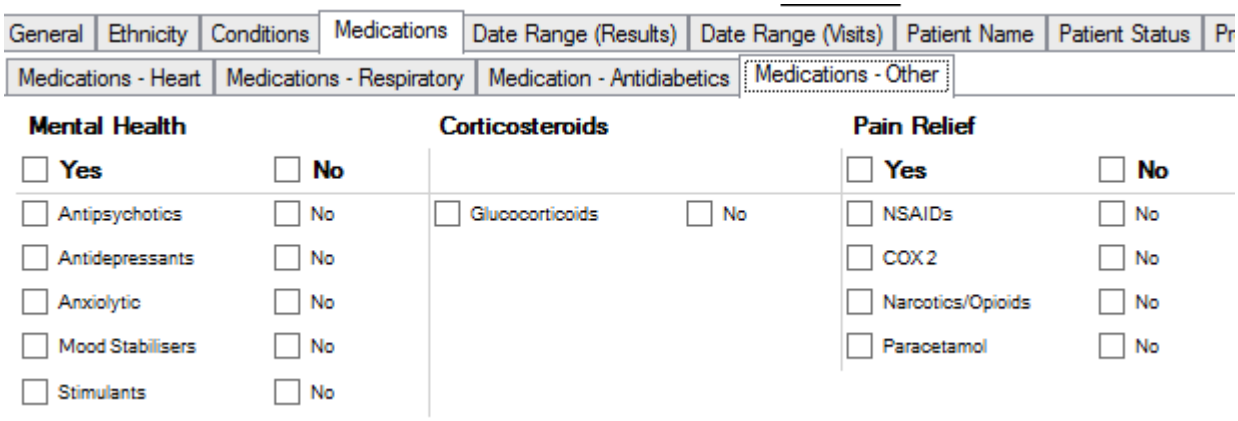
The co-morbidities report shows patients with a mental health condition and at least one of the following conditions:

- diabetes
- respiratory
- cardiovascular
- musculoskeletal
- renal impairment.

The data is displayed in a pie chart and lists patients with 1, 2, 3, 4 and more than 4 conditions.

Medication filtering

This search is useful to help to ensure medication lists are up to date and assist with appropriate medication prescribing. Medications are flagged as true if they are on the patient's current medication list. The collection process does not make any decisions about whether a medication should be removed from the current medication list. The GP is responsible for making sure the list of medications is accurate.



Activity 1.1 – Data collection from CAT4

The aim of this activity is to collect data to identify patients at risk of a mental health condition and also assist with the management of patients with a mental health condition

Complete the below table by collecting data from your CAT4 Data Extraction Tool.

Note - Instructions on how to extract the data is available from the CAT4 website. Number of patients with a mental health condition **or** Indicated mental health with no diagnosis **or** Number of patients with a mental health condition who may be eligible for a home medication review **or** Number of patients who have had a mental health treatment plan completed in the past 12 months **or** Number of patients on medications

	Description	Total number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
1.1a	Number of active patient population		
1.1b	Number of active patients (i.e.: 3 x visits in 2 years) See instructions in link below. Identify active patients with at least 3 visits in the last 2 years.		
1.1c	Number of patients with a mental health condition		
1.1d	Number of patients with indicated mental health but no diagnosis		
1.1e	Number of patients with a mental health condition who may be eligible for a home medication review *(on the instructions, select condition as mental health)*		
1.1f	Number of patients who have had a mental health treatment plan completed in the past 12 months		
1.1g	Number of patients with a mental health condition on antidepressant medications		
1.1h	Number of patients with a mental health condition on antipsychotic medications		
1.1i	Number of patients with a mental health condition on mood stabilisers		
1.1j	Number of patients with a mental health condition on pain relief medication		

***Please note**: the RACGP defines active as 3 x visits in 2 years. This search criteria does not capture those patients who may come in for screening every 2 years, or twice in 2 years e.g. flu vaccine, hence the option to look at all active patients.*

Reflection on Activity 1.1:

Practice name:	Date:
Team member:	

Activity 1.2 – Reviewing your practice mental health profile

Complete the checklist below to review your practice's mental health patients 'at risk' and diagnosed.

Description	Status	Action to be taken
After completing activity 1.1, are there any unexpected results with your practice's mental health profile?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients with mental health condition than expected or only a low percentage of patients with mental health condition have a MH treatment plan.)* How will this information be communicated to the practice team?
After reviewing your practice's mental health profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

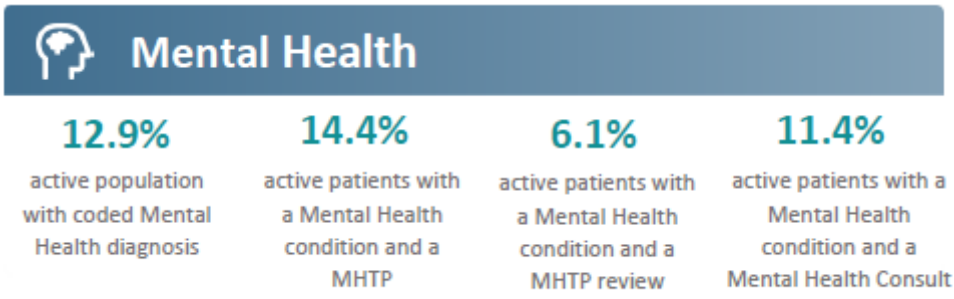
Reflection on Activity 1.2:

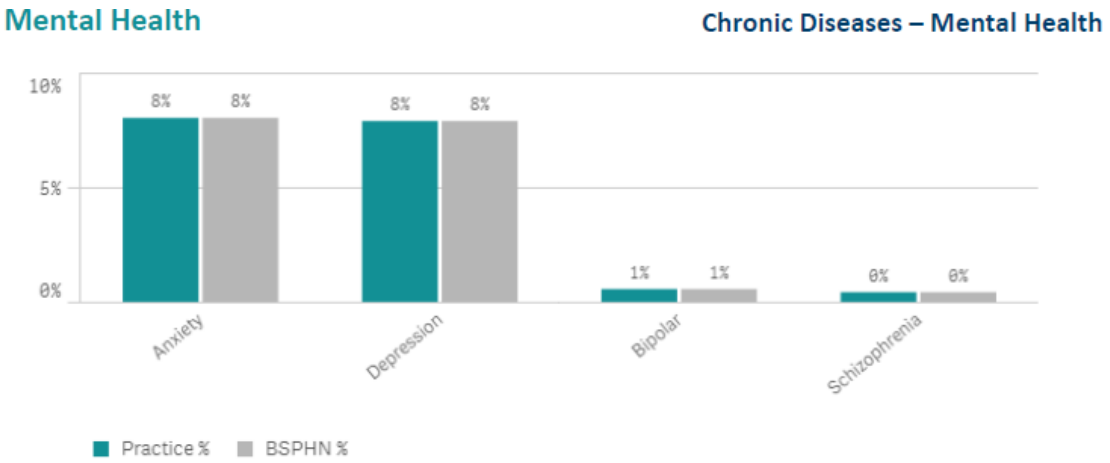
Practice name:	Date:
Team member:	

Activity 1.3 – Mental health measures on benchmark report

The aim of this activity is to review your practice's data dashboard on the monthly benchmark report provided by Brisbane South PHN.

You will need your practice's benchmark report to complete this information.





Mental Health Diagnosis*	-	- %	BSPHN	BSPHN %
Active Patients with a Mental Health diagnosis**	132,420		132,420	
Anxiety	82,115	8%	82,115	8%
Depression	80,736	8%	80,736	8%
Bipolar	5,710	1%	5,710	1%
Schizophrenia	4,297	0%	4,297	0%

	Description	Percentage
1.3a	Active population with coded mental health diagnosis	
1.3b	Active patients with a mental health condition and a mental health treatment plan	
1.3c	Active patients with a mental health condition and a mental health treatment plan review	
1.3d	Active patients with a mental health condition and a mental health consult	
1.3e	Active patients with a diagnosis of anxiety	
1.3f	Active patients with a diagnosis of depression	
1.3g	Active patients with a diagnosis of bipolar	
1.3h	Active patients with a diagnosis of schizophrenia	

Reflection on Activity 1.3:

Practice name:	Date:
Team member:	

Activity 1.4– Reviewing your practice mental health profile on the benchmark report

Complete the checklist below to review your practice's mental health profile from your benchmark report.

Description	Status	Action to be taken
After completing activity 1.3, are there any unexpected results with your practice's mental health profile?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. a low percentage of mental health patients have a mental health consult).* How will this information be communicated to the practice team?

Description	Status	Action to be taken
Is your practice mental health patient profile similar to other practices in the Brisbane South region (compare information from Benchmark report)?	☐ Yes: continue with activity. ☐ No: **see actions to be taken.**	Outline the differences – (*e.g. our practice has a lower percentage of patients with a mental health diagnosis than other practices).* How will this information be communicated to the practice team?
After reviewing your practice's mental health profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

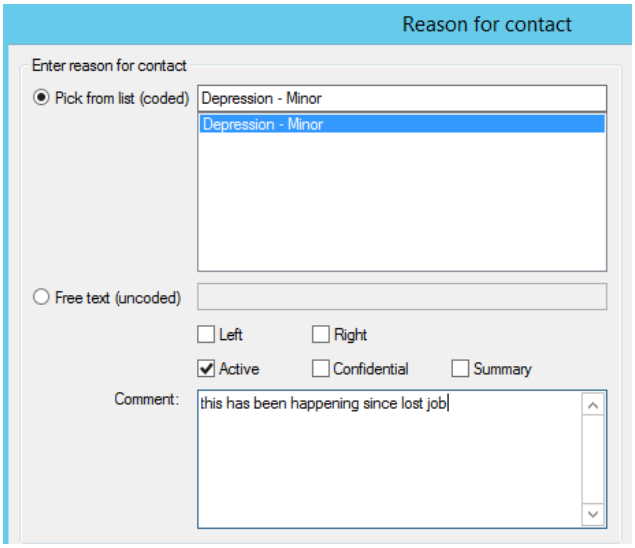
Reflection on Activity 1.4:

Practice name:	Date:
Team member:	

Activity 2 – Building your practice mental health register

Coding is simply a process of using an agreed standardised descriptor to store data as a series of numbers or letters. There are multiple ways clinical staff may enter a patient's diagnosis in practice software. Some will type this information directly into the patient progress notes or enter this information as free text in the 'reason for encounter' or 'diagnosis field'. This process is called free texting or un-coded diagnosis. Free text is not easily searchable in any database by the clinical software or third-party software (e.g. extraction tools).

If GPs require further information to describe the clinical condition, then include this in a descriptor field. If a particular coded diagnosis is not available, contact your software provider (see example image).



The recommended process is to use a diagnosis from the drop-down boxes provided in the clinical software. This is a coded diagnosis. If all clinical staff within the practice use the same codes to identify a diagnosis then it is easier to search for particular conditions.

It is important to ensure your coding is consistent and agreed upon by all clinical staff in the practice, and diagnostic criteria for mental health are uniform. The following activity will guide you through this process.

This resource highlights the benefits of having good quality data within your clinical software.

Time required to…	Good Data	Poor Data
Write a referral*	5 minutes	Up to 10+ minutes
Upload a shared health summary to the My Health Record*	30 seconds	Up to 5+ minutes
Write & print a Health Summary*	30 seconds	Up to 5+ minutes

**These are approximate estimations and will vary depending on the quality of data and software within your individual practice. These figures should be used as a guide.*

Advantages and disadvantages of labelling a mental illness

If someone has a mental health diagnosis it is important it is recorded correctly so that the treating team are aware for safety and to allow correct treatment (and to lessen stigma). Any diagnosis should be discussed with the person. Just as we would record a physical health diagnosis, a mental health condition should recorded if it has been diagnosed. If preferred, it may be marked as confidential, or inactive if no longer of concern, and people may choose not to upload it to My Health Record if desired.

Activity 2.1 – Determine terms of consistent coding

The aim of this activity is for the clinical team to agree on consistent coding to be used within the practice.

Description	Status	Action to be taken
Are relevant practice team members aware of the importance of quality data including using consistent coding (avoiding free text)?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Organise a practice team meeting to discuss how to develop a clinical coding policy for your practice. This may be a specific area that the practice is working on, to make it task easier.
Have you agreed on accepted terminology of mental health conditions from the drop-down lists in your practice software?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Source list of clinical codes already available in current clinical software. Source list of clinical codes from CAT4 clinical audit tool. From these two lists agree on clinical codes for mental health to be used within practice. _____ _____ _____ _____
Have your agreed clinical codes been included in your practice policy?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Record agreed clinical codes in practice policy manual.

Description	Status	Action to be taken
Are practice team members aware of how to enter diagnoses in clinical software using agreed mental health conditions?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	See instructions for Best Practice users. See instructions for Medical Director users.
After reviewing your practice's clinical coding guidelines, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken to help set your goals.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 2.1:

Practice name:	Date:
Team member:	

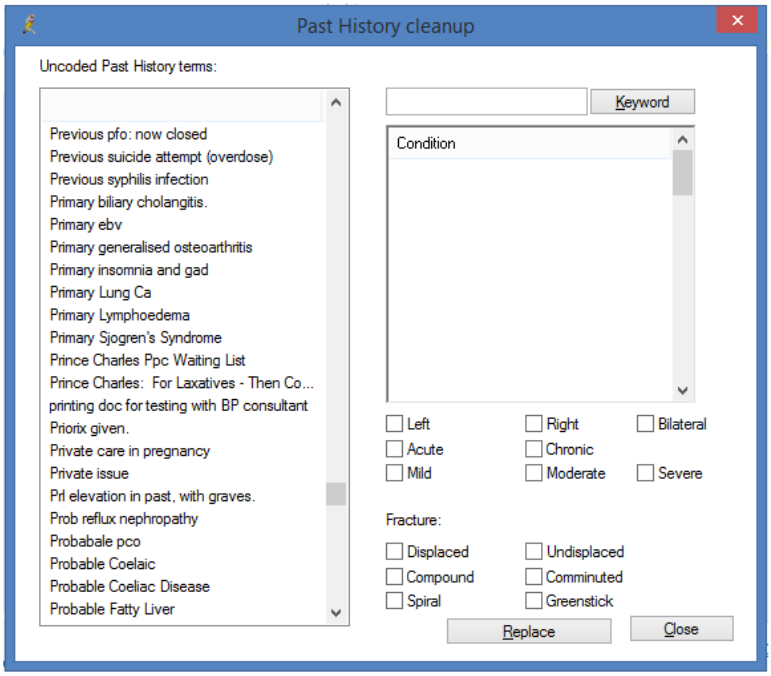
Activity 2.2 – Cleaning up un-coded conditions in your practice software

You can clean up un-coded conditions that have been recorded in your practice software. Cleaning up un-coded items makes it easier to perform database searches and manage third-party clinical audit tools.

*Instructions for cleaning up un-coded conditions in **Best Practice***

It is also possible to clean up un-coded conditions that have been recorded in the **Past History** section of Best Practice. This can assist when performing database searches or using 3rd party Clinical Audit tools.

This cleanup is done via the **BP Utilities** function. Select **Start > Programs > Best Practice Software > Best Practice > BP Utilities**. Select your user name from the drop-down list. You will only have access to this function if you have sufficient user permissions.



Double click on the 

icon. The **Past History cleanup** screen will appear.

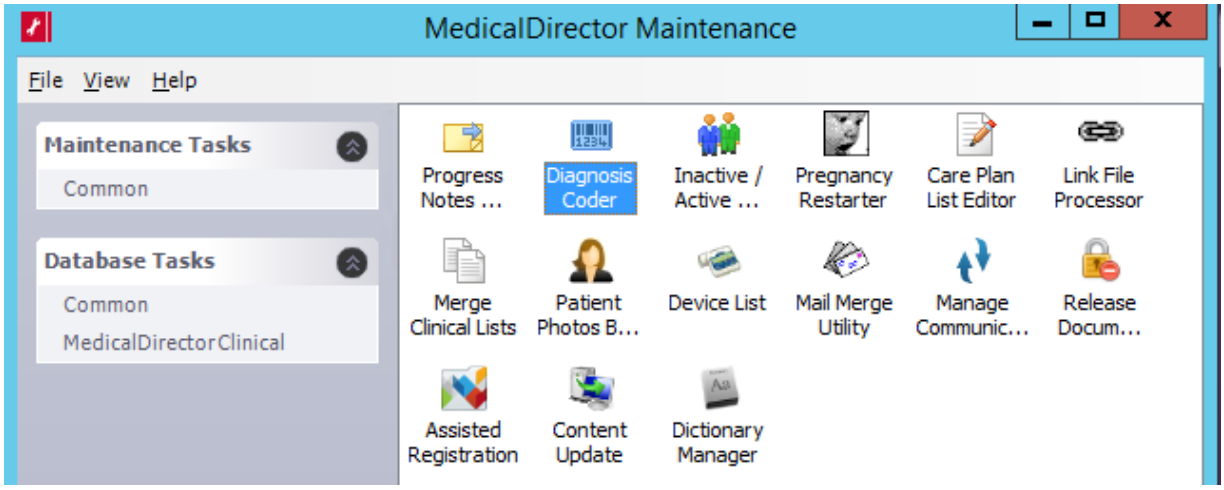
Un-coded Past History is a current list of all past history entries entered into the database (usually from a conversion or free texted), and the **Conditions** column is the complete list of coded conditions entered into Best Practice.

On the left-hand side, highlight the item that will be merged to a coded condition. On the right-hand side, enter the coded condition into the keyword search field. Highlight the condition to merge to, then select the **replace** button.

Instructions for cleaning up un-coded conditions in Medical Director

Medical Director provides a simple utility in **HCN Maintenance** that enables you to easily find un-coded past medical history items, and either link them to a coded item or replace them with the correct coded item.

1. Double click the **HCN Maintenance icon** to open HCN Maintenance.
2. Select **Medical Director Clinical** in the list of **Database Tasks** on the left of the window.
3. Double click the **Diagnosis Coder** icon 



The left-hand panel of this screen contains all the un-coded diagnosis entries in the Past Medical History database. The right-hand panel displays coded entries to pair-up with your un-coded entries. Note that the right-hand panel is initially empty, but as you type into the text box above it, a list of items is generated underneath.

Simply highlight the entry on the left and the one you want to link or replace it with on the right, and then click either the **Link** or **Correct** button.

The **Link** button will attach the code for that diagnosis to the coded entry on the right. The **Correct** button will change the diagnosis on the left to that on the right (i.e. if the word was misspelled).

Reflection on Activity 2.2:

Practice name:	Date:
Team member:	

Activity 2.3 – Marking mental health condition as active/inactive

It is important when completing each patient's progress notes, to mark the consult with an appropriate condition. PLEASE NOTE: if a mental health condition is marked as 'active' the patient will be included in any appropriate reports produced on CAT4. If the condition is marked 'inactive', they will not be included in CAT4 reports. The clinical team should understand the importance of marking conditions as active or inactive.

The aim of this activity is to ensure all the clinical team within the practice understand the importance of marking conditions as active or inactive.

Description	Status	Action to be taken
Are relevant practice team members aware of the importance of marking conditions or reason for visits as active or inactive?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Include in the next clinical team meeting/s the importance of marking patient's history and/or reason for visit as active or inactive.
Are relevant practice team members aware that they can mark sensitive information as confidential?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Include in the next clinical team meeting/s some information on marking patient's history and/or reason for visit as confidential. This is generally only done for very sensitive information.
Does your practice policy and procedure manual include a section on marking patient past history and/or conditions as active or inactive?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	Update policy and procedure manual.
Are practice team members aware of how to enter active/inactive in your practice's clinical software?	☐ Yes: continue with this activity. ☐ No, **see action to be taken.**	See instructions for Best Practice users. See instructions for Medical Director users.

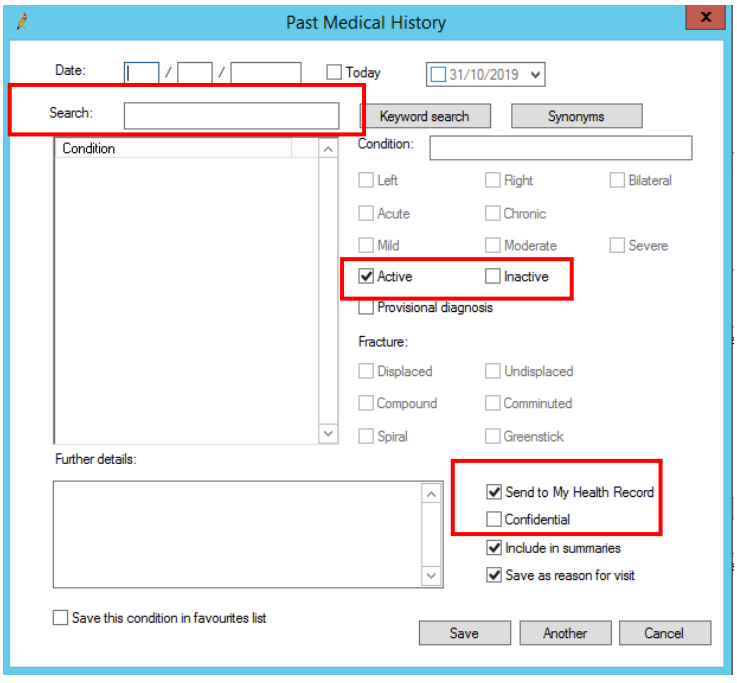
Description	Status	Action to be taken
After reviewing your practice's active/inactive conditions processes, are there any changes you would like to implement in the practice, to help manage patients over the next 12 months?	☐ Yes**, see actions to be taken to help set your goals.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 2.3:

Practice name:	Date:
Team member:	

Instructions for adding active, inactive or confidential to Best Practice notes

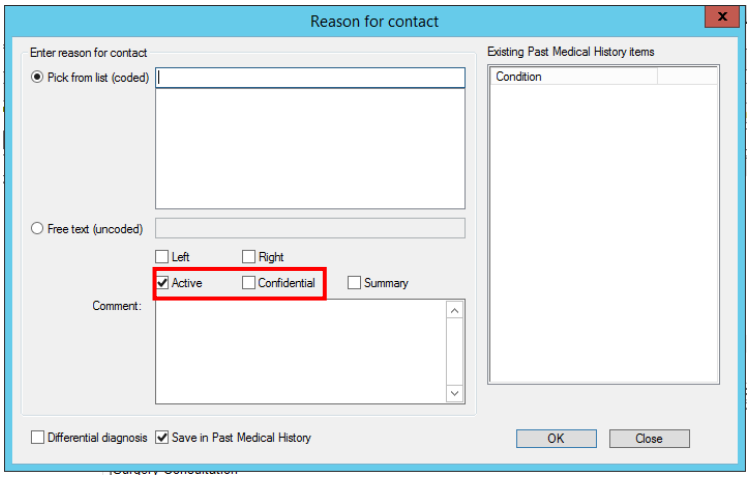
1. In the **past medical history** screen, select the condition in the **search** field.
2. Then tick either **Active** or **Inactive**
3. You may wish to remove from sending to **My Health Record**
4. Mark item as **Confidential** if extremely sensitive.
5. Select **Save** to complete.

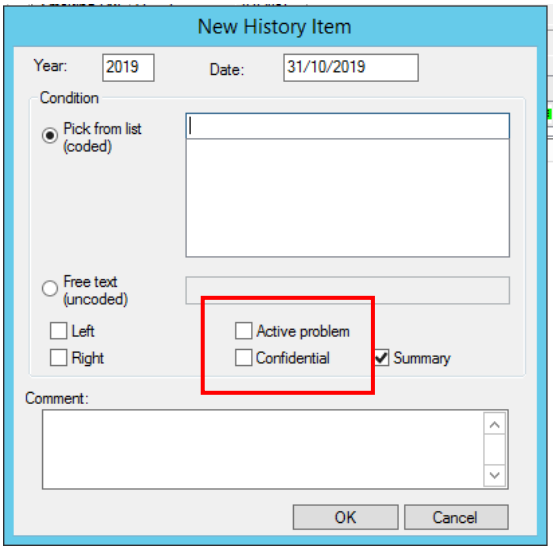


The 'Confidential' box marks history items as confidential and these will not appear in materials such as Referral Letters and Reports. This feature is intended for very sensitive personal health information only.

Instructions for adding active, inactive or confidential to Medical Director notes

1. In the **reason for contact** or **new history item** screen, select the condition in the **pick from list** field.
2. Then tick **Active** if relevant.
3. In the reason for contact screen, you can choose to save in past medical history for significant problems.
4. Mark item as **Confidential** if extremely sensitive.
5. Select **ok** to complete.





By default, the procedure is marked as Active. To change this, clear the **Active** check box

Activity 2.4 – Confirming the right patients are on the register

Patients with mental health diagnosis are central to the patient register. The aim of this activity is to look at patients with indicated mental health with no diagnosis reported.

Instructions on how to conduct this search can be found here.

Description of patient list	Patient information is updated in clinical software where relevant	Patient information is included in mental health register where relevant	Completed
Active patients with indications for mental health with NO diagnosis The "Indicated mental health with no diagnosis" report will display the likelihood of a mental health condition based on a mental health medication or a mental health care plan being recorded in the patient record without a diagnosis.			

Reflection on Activity 2.4:

Practice name:	Date:
Team member:	

Practice decision point

It is recommended that you have a practice meeting to review the data collection table results and determine any action that needs to be taken. The table below will help guide you through this process.

Activity 2.5 – Distribute list of patients with indicated mental health with no diagnosis to individual GPs

Description	Action to be taken	
After completing activity 1.1, note how many active patients have indicated mental health with no diagnosis.	Number: _____	
Is there an explanation for this result?	(*e.g. coding issue, information inconclusive etc.):* _____ _____ _____	
Have you distributed lists to individual GPs for review and update of their diagnosis?	☐ Yes Ensure you follow up in a week's time to receive the reviewed reports back from the GP. You have completed this activity.	☐ No Follow the instructions to complete this.

Please note: CAT 4 assigns providers in the following ways:

Best Practice: Best Practice uses the 'Usual Doctor' field in the patient demographics as the patients assigned provider. Where a 'Usual Doctor' is not selected, patients will be assigned to a particular provider based on which provider they were most frequently seen by in recent consultations. Patients will be assigned to the active provider who saw them for the highest number of consultations in the previous 18 months.

Medical Director: Where there is more than one provider in the practice, patients will be assigned to a particular provider based on which provider they were most frequently seen by in recent consultations. Providers that are active will be given priority over providers that have been made inactive. Patients will be assigned to the provider who saw them for the highest number of consultations in the previous 18 months.

Reflection on Activity 2.5:

Practice name:	Date:
Team member:	

Activity 2.6 – Build a system to maintain your mental health patient register:

In a team meeting, discuss the following:

Topic	Question to consider	Action to be taken
Maintaining the database.	Appoint a 'database manager' who will review the register, perform the searches as outlined in the toolkit and report back to the practice.	Who will this be?
	Will this person require training?	Yes ☐ No ☐ If yes, who will provide it and when will it take place?
	How much 'protected time' will this person require to maintain the database?	
	Is that amount of time reasonable and will it fit within their workload?	
	Implement a system to ensure this continues when the 'database manager' is away and/or leaves.	Who else will be responsible?

Topic	Question to consider	Action to be taken
	Do they also require training?	Yes ☐ No ☐ If yes, who will provide it and when will it take place?
	How will you document your system for maintaining the database so the system works even when the database manager is away? i.e. in policies and procedures	
A system for ensuring new information is gathered and recorded.	How will new cases be identified or existing cases updated when there is a change in diagnosis?	
	How will the information reach the database manager and be coded appropriately?	
	How will GPs notify the 'database manager' of changes to patient information?	
Reviewing the database to confirm validity.	How frequently will the database manager check the quality of the information on the database?	
	Are all patients still active?	Yes ☐ No ☐
	Are clinicians actively entering diagnosis correctly?	Yes ☐ No ☐

Please note: the definition of "database" is referring to the clinical software program that is used by your practice. (*for e.g.: Medical Director, Best Practice, Genie etc*)

Reflection on Activity 2.6:

Practice name:	Date:
Team member:	

Activity 3. Identifying patients with mental health conditions and other chronic medical conditions

Activity 3.1 –Data collection from CAT4

The aim of this activity is to collect data to identify patients with mental health and at least one other chronic medical condition

Mental illnesses are associated with a higher risk of obesity, diabetes and cardiovascular disease. [5] Identifying this comorbidity allows for more effective management of both physical and mental health. Chronic health problems can also increase the likelihood of a mental health problem, or confound efforts to better manage a physical health problem.

Complete the below table by collecting data from your CAT4 Data Extraction Tool. Note - Instructions on how to extract the data is available from the CAT4 website: co-morbidities OR chronic conditions.

	Description	Total number of active patients as per RACGP criteria (3 x visits in 2 years)	Total number of active patients
3.1a	Number of patients with a mental health condition and 1 other chronic medical condition		
3.1b	Number of patients with a mental health condition and 2 other chronic medical conditions		
3.1c	Number of patients with a mental health condition and 3 other chronic medical conditions		
3.1d	Number of active patients with a mental health condition and diabetes *(select Mental Health yes & Diabetes Yes and recalculate)*		
3.1e	Number of active patients with a mental health condition and cardiovascular disease *(select **Mental Health yes** & **Cardiovascular yes**)*		

Please note: You can search lists by individual providers and provide to them to identify patients with multiple chronic conditions.

[5] https://www.thelancet.com/pdfs/journals/lanpsy/PIIS2215-0366(19)30132-4.pdf

Reflection on Activity 3.1:

Practice name:	Date:
Team member:	

Activity 3.2– Reviewing your patients with multiple chronic medical conditions

Complete the checklist below to review your patients with multiple chronic medical conditions.

Description	Status	Action to be taken
After completing activity 3.1 are there any unexpected results with your patients' comorbidities?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. higher number of patients with mental health condition and 3 other chronic medical conditions).* How will this information be communicated to the practice team?
After completing activity 3.1, do you have any unexpected results about the number of patients with a mental health condition & diabetes?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Consider completing a Diabetes Cycle of Care. Refer to MBS online for criteria. Information to assist with patients with a mental health condition & diabetes is available from Diabetes Australia. Refer to Brisbane South PHN's QI Toolkit – Chronic Conditions - Diabetes.

Description	Status	Action to be taken
After completing activity 3.1, do you have any unexpected results about the number of patients with a mental health condition & cardiovascular disease?	☐ Yes: **see actions to be taken,** ☐ No: continue with activity,	Consider a medication review, Consider recalling the patient to check if they are meeting treatment goals. Refer to Brisbane South PHN's QI Toolkit – Chronic Conditions – Cardiovascular,
After reviewing your practice's comorbidities profile, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes: **see actions to be taken.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 3.2:

Practice name:	Date:
Team member:	

Activity 4. Preventative health for patients with a mental health condition

Looking after physical health is important for everyone, but it can be an extra challenge for people who have a mental illness.

This may be related to the symptoms of the illness or the side-effects of medication. It may be due to smoking, not getting enough exercise, or other lifestyle factors. Physical health problems can also get overlooked when everyone's focus is on looking after the mental health condition.

Whatever the reasons, people affected by mental illness often have some of the following problems:

- weight gain
- high blood pressure
- high cholesterol
- high blood glucose levels.

These problems may lead to heart disease, diabetes or other illnesses. Being physically and mentally healthy in day-to-day life can make a big difference.

The aim of this activity is to look at preventative health options for patients with a mental health condition. This will include:

- physical activity
- alcohol
- smoking
- weight and BMI
- other risk factors including blood pressure, BSL.

Mental health conditions and cancer screening

People with mental health conditions are also potentially less likely to participate in cancer screening. Brisbane South PHN has a cancer screening toolkit to assist with identifying under-screened patients.

Recording risk factors in your clinical software

It is important to record activities in the correct data fields and avoid entering the activities as 'free text' in the progress notes. By recording the information in the correct fields, it will:

- improve efficiency when using your software package by reducing the amount of time needed to search for information in the patient progress notes
- improve consistency in how data is entered across all patients at the practice
- allow the Pen Clinical Audit tool to extract accurate data on patients.

Physical Activity

As defined in the most recent RACGP report supporting Australia's physical activity and sedentary guidelines for adults, six terms apply to this section:

- physical activity
- sedentary behaviours
- metabolic equivalent (MET)
- intensity
- frequency
- duration.

Physical activity is important for mental health, pain management, a range of chronic disease and also disease prevention and health promotion.

Activity 4.1 – Data Collection from CAT4

Complete the below table by collecting data from your practice monthly benchmark report.

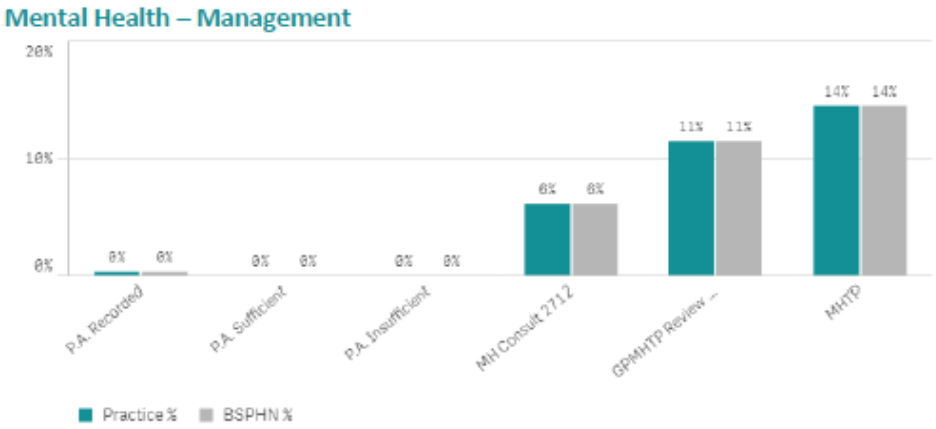
The aim of this activity is to collect data to determine the number of patients with their physical activity recorded.

	Description	Total Number	% completed	Accreditation target met
4.1a	Number of active patients who have their physical activity recorded			□ Yes □ No
4.1b	Number of active patients with a mental health condition who have their physical activity recorded			

Please note: As a general rule, data recording in this area is low across all practices in the Brisbane South PHN area. If the option for data recording is not user friendly at your practice, please notify your software provider.

Reflection on Activity 4.1:

Practice name:	Date:
Team member:	



Mental Health Management*	-	- %	BSPHN	BSPHN %
Active Patients with a Mental Health diagnosis**	132,420	-	132,420	-
Physical Activity Recorded	384	0%	384	0%

Figure: Sample snapshot of Brisbane South PHN benchmark report – mental health - management

Activity 4.2 – Understanding your practice physical activity status

The aim of this activity is to increase your understanding of the patient's physical activity status.

Description	Status	Action to be Taken
After completing activity 4.1, are there any unexpected results with your practice's patient physical activity status?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. low recording of physical activity status,*) How will this information be communicated to the practice team?

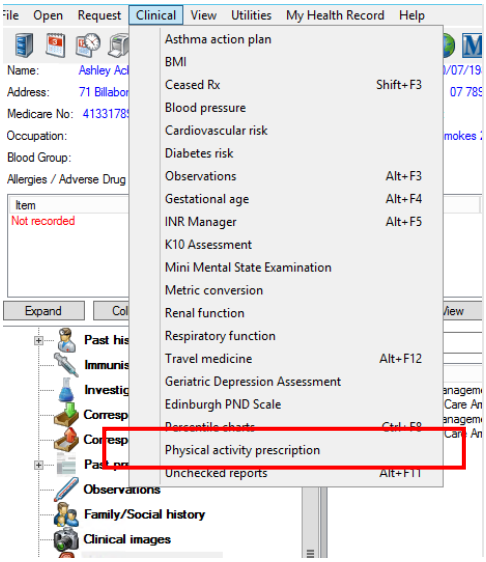
Description	Status	Action to be Taken
Are your practice patient measures similar to those at other practices in the Brisbane South region (*compare information from Benchmark report)*?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	Outline the differences (*e.g.: we're on similar par to other practices, others are doing much better than us*). How will this information be communicated to the practice team?
Do all clinicians know how to enter physical activity status in your practice's clinical software?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	See instructions on how to enter into Medical Director or Best Practice.
After reviewing practice physical activity status, are there any changes you would like to implement in the practice, to help using practice software, over the next 12 months?	☐ Yes, **see actions to be taken to help set you goals.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

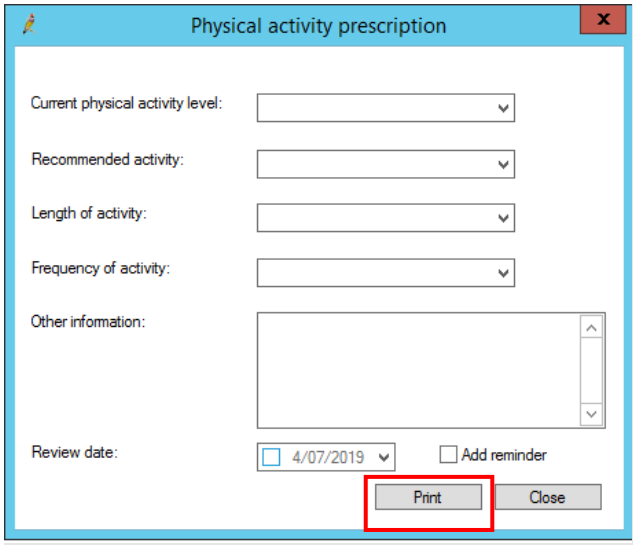
Reflection on Activity 4.2:

Practice name:	Date:
Team member:	

Entering physical activity information in the patient file in Best Practice

1. Open the patient file.
2. Select **Clinical** > **Physical Activity Prescription.**

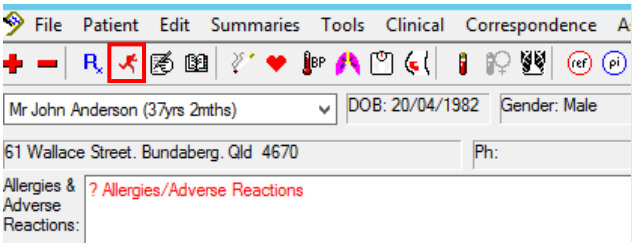




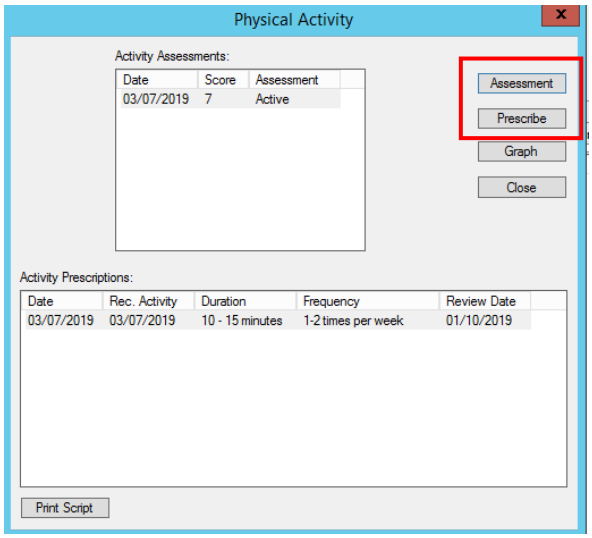
3. Complete the physical activity by using the drop-down menu options.
4. Click **Print** to save.

Entering physical activity information in the patient file in Medical Director

1. Open the patient file.
2. Click on the Physical Activity Prescription (red person running) on the toolbar.



3. You can then complete an assessment or prescribe the patient a physical activity prescription.



Smoking and Alcohol status

In Australia, while the prevalence of smoking is declining in the general community, it remains high among people with mental illness. Compared with the general population, people with mental illness have higher smoking rates, higher levels of nicotine dependence, and a disproportionate health and financial burden from smoking.[6]

Alcohol can have a major impact on mental health. Because alcohol is a depressant, it slows the body down and changes the chemical makeup in the brain. This has many effects. It can alter:

- mood
- energy levels
- sleeping patterns
- concentration
- memory
- and also increase risk of injury.

Alcohol reduces inhibitions and impacts decision making. [7]

[6] https://www.tobaccoinaustralia.org.au/chapter-7-cessation/7-12-smoking-and-mental-health
[7] https://headspace.org.au/young-people/how-does-alcohol-affect-mental-health/

Activity 4.3 – Data Collection from CAT4

Complete the below table by collecting data from your PIP QI measures from your practice monthly benchmark report. You can also collect information from CAT4. The recipe is available here (***change condition to mental health***)

The aim of this activity is to collect data to determine the number of patients who have their smoking and alcohol status recorded.

	Description	Percentage	Number
4.3a	Number of active patients aged 15+ years with smoking status recorded as current smoker PIP QI		
4.3b	Number of active patients aged 15+ years with an alcohol consumption status recorded PIP QI		
4.3c	Number of active patients with a mental health condition who are current smokers		
4.3d	Number of active patients with a mental health condition who drink alcohol		

Please note: not all patients included in the PIP QI reports will have a mental health condition. You can produce reports from CAT4 to include just mental health condition patients.

Reflection on Activity 4.3:

Practice name:	Date:
Team member:	

Activity 4.4 – Understanding your practice alcohol and smoking status

The aim of this activity is to increase your understanding of the patient's alcohol and smoking status.

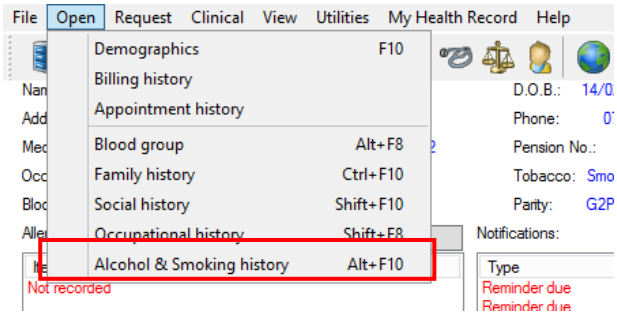
Description	Status	Action to be Taken
After completing activity 4.3, are there any unexpected results with your practice's patient alcohol and smoking status?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. high number of patients with a mental health condition who drink alcohol*). How will this information be communicated to the practice team?
Do all clinicians know how to enter alcohol and smoking status in your practice's clinical software?	☐ Yes: continue with activity. ☐ No: **see action to be taken.**	See instructions on how to enter into Medical Director or Best Practice.
After reviewing your data on alcohol and smoking status, are there any changes you would like to implement in the practice, to help using practice software, over the next 12 months?	☐ Yes: **see actions to be taken to help set you goals.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

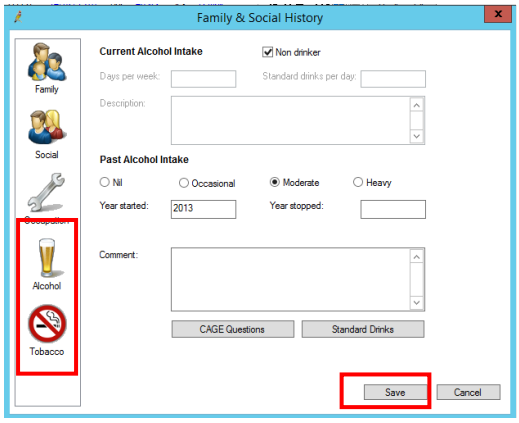
Reflection on Activity 4.4:

Practice name:	Date:
Team member:	

Instructions for entering alcohol and smoking status in Best Practice

1. While the patient file is open, select **Open** > **Alcohol & smoking history**

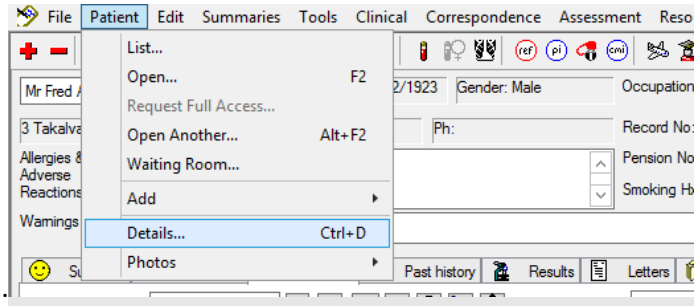




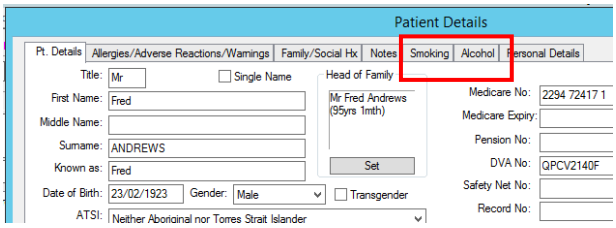
2. Select **Tobacco** on the left-hand side menu.
3. Once you have entered the information, select **Alcohol.**
4. Select **Save** to complete.

Instructions on entering alcohol and smoking status into Medical Director

1. Open the patient file.
2. From the '**Patient'** menu select '**Details'**.



3. This will open a screen where you can enter patient details, allergy/reactions, family/social history, smoking, alcohol and personal details.
4. Select **Smoking.**



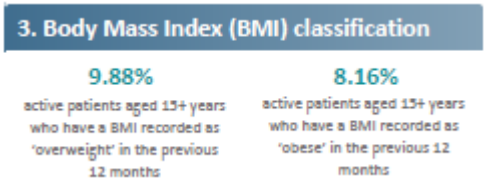
5. Once you have entered the details, select **Alcohol.**
6. Once all details have been completed select **Save**.

Weight, BMI and other risk factors

Sometimes people feel down or anxious about their weight. They may feel guilty for not being healthy and energetic. They may blame themselves for not being fit and active. As well, if a person has depression or anxiety, their appetite, energy levels, self-esteem and weight can all be affected.[8]

Activity 4.5 – Data Collection from CAT4

Complete the below table by collecting data from your PIP QI measures from your practice monthly benchmark report.



The aim of this activity is to collect data to determine the number of patients with their BMI recorded as overweight or obese

	Description	Percentage
4.5a	Number of active patients aged 15+ years who have a BMI recorded as 'overweight' in the previous 12 months	
4.5b	Number of active patients aged 15+ years who have a BMI recorded as 'obese' in the previous 12 months	

Please note: not all patients included in these reports will have a mental health condition. You can complete a search on CAT4 to include just patients with a mental health condition.

Reflection on Activity 4.5:

Practice name:	Date:
Team member:	

[8] http://healthyweight.health.gov.au/wps/portal/Home/keep-in-check/managing%20the%20challenges/mental-health-and-weight/!ut/p/a0/04_Sj9CPykssy0xPLMnMz0vMAfGjzOI9jFxdDY1MDD3dzbycDTzNLfwsfP0MjYJNTfULsh0VAUgJjsw!/

Activity 4.6 - Recording weight and risk factors in your clinical software

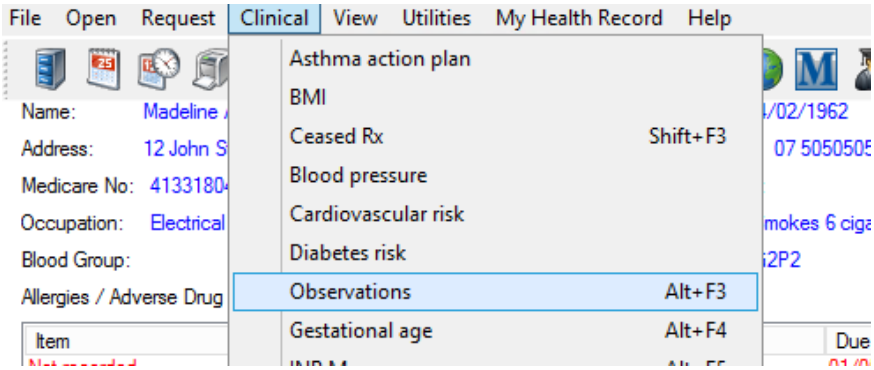
Description	Status	Action to be taken
Are all the risk factors being recorded in the correct fields in your clinical software? (e.g.: BP, BMI, waist circumference etc,)	☐ Yes: you have completed this activity. ☐ No, **see action to be taken.**	Review how and where your risk factor information is being recorded in your practice software. See instructions on entering information in Best Practice. See instructions on entering information in Medical Director. Ensure all relevant team members are aware of how to record risk factor information. Document in practice policy.

Reflection on Activity 4.6:

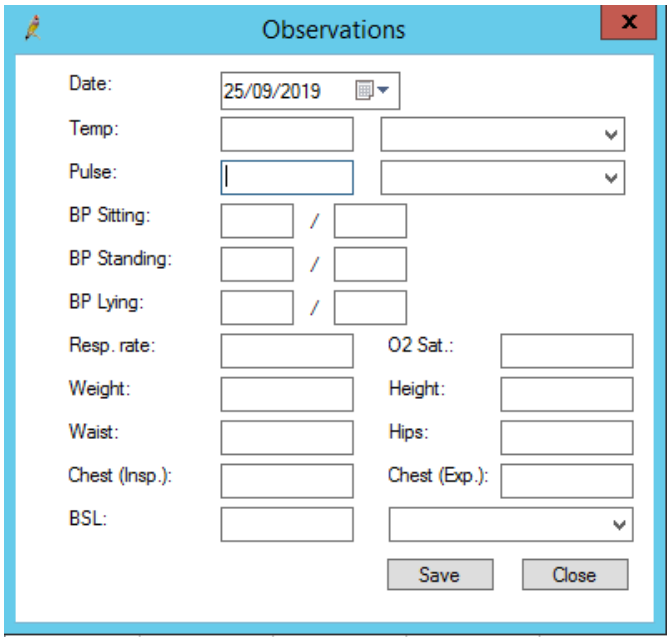
Practice name:	Date:
Team member:	

Instructions on entering measurements into Best Practice

1. Open the patients file.
2. From the top menu, select **Clinical** > **Observations**



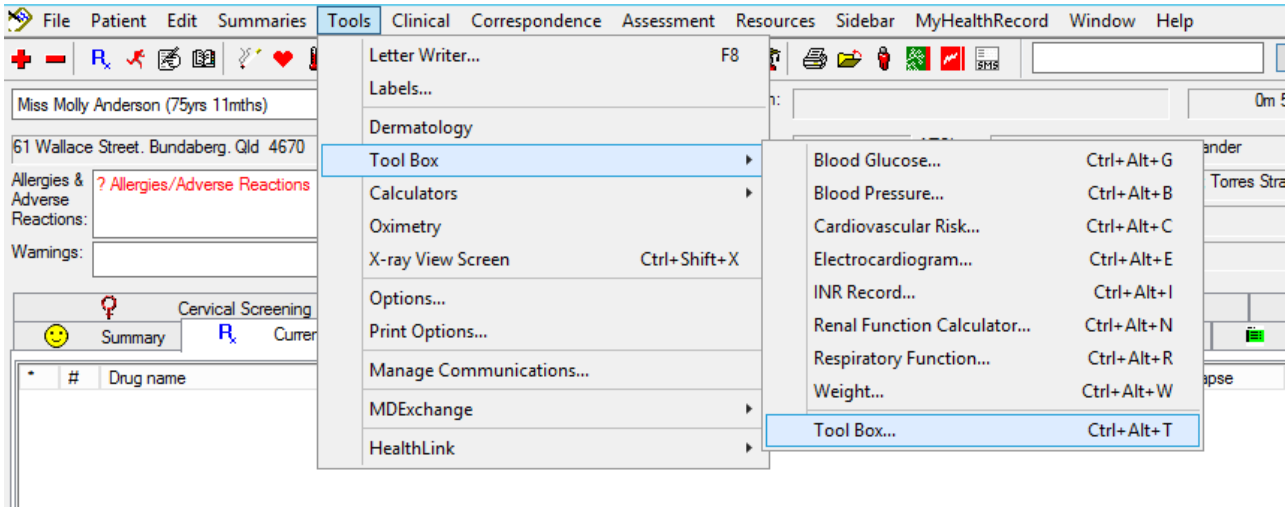
3. Enter the appropriate information.



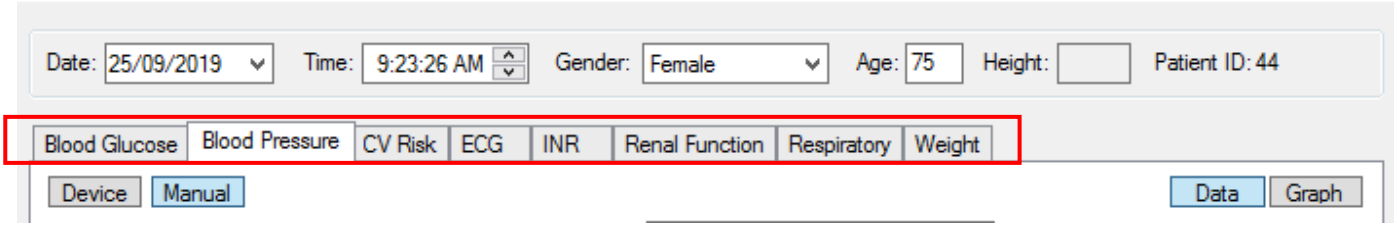
4. Click **Save** to complete.

Instructions on entering measurements into Medical Director

1. Open the patient file.
2. From the top menu select **Tools** > **Tool Box** > **Tool Box**



3. Select the appropriate tab and enter the relevant information.



4. Click **Save** to complete.

Activity 5. Medicare item numbers for patients with a mental health condition

Patients with a mental health condition ***may be eligible*** to access item numbers within the Medicare Benefit Schedule (MBS). These are dependent on patient age, ethnicity and co-morbidities. Conditions apply to each item number; please ensure the GP understands these prior to claiming the item number/s. Brisbane South PHN has a comprehensive toolkit looking at MBS items. Item numbers include:

Better access to psychiatrists, psychologists and general practitioners through the MBS (Better Access) initiative

The purpose of the Better Access initiative is to improve the treatment and management of mental illness within the community. The Better Access initiative is increasing community access to mental health professionals and team-based mental health care, with general practitioners encouraged to work more closely and collaboratively with psychiatrists, clinical psychologists, registered psychologists and appropriately trained social workers and occupational therapists. Part of the Better Access funding has been allocated to education and training for health professionals.

Education and training

As GPs are often the first point of contact for patients experiencing a mental illness, they are the most common providers of mental health services. Therefore, it is essential that they have the necessary skills and knowledge to address patients' mental health needs.

The training accredited by the GPMHSC provides the fundamental skills required to assess a patient's needs, recommend appropriate referral options and manage a patient's ongoing mental health care.

Mental health consultation (item 2713)

The GP mental health treatment consultation item is for an extended consultation with a patient where the primary treating problem is related to a mental illness including for a patient being managed under a GP Mental Health Treatment Plan. This item may be used for ongoing management of a patient with a mental health condition. This item should not be used for the development of a GP Mental Health Treatment Plan.

A GP mental health treatment consultation must include:

- taking relevant history and identifying the patient's presenting problem(s) (if not previously documented)
- providing treatment, advice and/or referral for other services or treatment
- documenting the outcomes of the consultation in the patient's medical records and other relevant mental health plan (where applicable).

A patient may be referred from a GP mental health treatment consultation for other treatment and services as per normal GP referral arrangements. This does not include referral for Medicare rebateable services for focussed psychological strategy services, clinical psychology or other allied mental health services, unless the patient is being managed by the GP under a GP Mental Health Treatment Plan.

Consultations associated with this item must be at least 20 minutes duration. There are no limits to the amount of times this item number is claimed.

Mental Health treatment plan (MBS item 2700, 2701, 2715 or 2717)

GPs providing mental health treatment plans, and who have undertaken mental health skills training recognised through the General Practice Mental Health Standards Collaboration, have access to items 2715 and 2717.

Item Description	Medicare Criteria	Frequency of claiming
Mental health plan MBS Items 2700, 2701, 2715 or 2717)	A mental health disorder is a term used to describe a range of clinically diagnosable disorders that significantly interfere with an individual's cognitive, emotional or social abilities. The mental health plan must include: • documenting the results of assessment, patient needs, goals and actions, referrals and required treatment/services • review date.	A new plan may be completed after 12 months if clinically required and if the person meets the eligibility criteria. After the plan has been completed, the patient is entitled to up to 10 Medicare subsidised visits (6 visits initially, another 4 after a review) with a Psychologist per calendar year. Full details of the criteria can be found here.

More information is available at Education guide for Mental Health Care

Mental health treatment plan review (MBS item 2712)

The review item is a key component for assessing and managing the patient's progress once a GP mental health treatment plan has been prepared, along with ongoing management through the GP mental health treatment consultation item and/or standard consultation items. A patient's GP mental health treatment plan should be reviewed at least once.

A rebate can be claimed once the GP who prepared the patient's GP mental health treatment plan (or another GP in the same practice or in another practice where the patient has changed practices) has undertaken a systematic review of the patient's progress against the GP mental health treatment plan.

The review must include:

- recording the patient's agreement for this service
- a review of the patient's progress against the goals outlined in the GP mental health treatment plan
- modification of the documented GP mental health treatment plan if required
- checking, reinforcing and expanding education
- a plan for crisis intervention and/or for relapse prevention, if appropriate and if not previously provided
- re-administration of the outcome measurement tool used in the assessment stage, except where considered clinically inappropriate.

A mental health plan review can be claimed every 3 months or at least 4 weeks after claiming the mental health plan item number.

Clinical psychologist (MBS items 80000 to 80021)

The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule initiative commenced on 1 November 2006. Under the Better Access initiative, MBS items provide Medicare benefits for the following allied mental health services:

AHP Group	Item Number	Service Provided	Eligible Patients	Prerequisite for Claiming
Clinical Psychologist (see also Psychologist)	80000	Psychological therapy Service	Patients with an assessed mental health disorder	GP mental health care plan, referral for psychiatric assessment management plan (item 291), and/or relevant psychiatrist or paediatrician item must have been claimed.
	80005			
	80010			
	80015			
	80020			

More information can be found at the MBS.

Mental health conditions and medication reviews (MBS item 900)

People with mental health conditions may be on medications and particularly those with other chronic diseases or who are elderly may be polypharmacy.

- GPs may be able to claim a Medicare item number to complete a Home Medication Review in conjunction with a community pharmacist. Updates on the Medicare Benefit Schedule (MBS) item numbers, including fees and item number criteria, are available at MBS Online.

Aboriginal and Torres Strait Islander health assessment (MBS 715) (if relevant)

The Aboriginal and Torres Strait Islander people's health assessment is available to:

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

See MBS descriptor for more information

Mental health conditions and health assessments (MBS item 701-707)

Some patients with a mental health condition may be eligible for a health assessment. A health assessment is the evaluation of an eligible patient's health and wellbeing. General practitioners use it to help decide if a patient needs:

- preventive health care
- education to improve their health and wellbeing
- appropriate interventions.

There are also time-based MBS health assessment items: **701 (brief), 703 (standard), 705 (long)** and **707 (prolonged)**. If you are a non-vocationally registered GP, the following item numbers can be claimed**: 224 (brief), 225 (standard), 226(long)** and **227 (prolonged)**.

More information is available from MBS.

Activity 5.1 – Checklist for reflection on MBS claiming

Complete the checklist below to review your practice's MBS claiming for patients with a mental health condition.

Description	Status	Action to be taken
Are there any patients with a mental health condition without a mental health treatment plan completed in the past 12 months? See activity 1.1	☐ Yes, **see action to be taken.** ☐ No, continue with the activity.	Please explain. What action will you take?
Are there any patients with mental health conditions who may benefit from a Home Medication Review? See activity 1.1. (*note: not all patients with mental health will be eligible for a HMR, refer to MBS criteria*).	☐ Yes, **see action to be taken.** ☐ No, continue with the activity.	Please explain. What action will you take? How will you use this information to increase the number of Home Medication Reviews completed?
Have you created a TopBar prompt on all patients with mental health conditions who may be eligible for a mental health treatment Plan?	☐ Yes: continue with activity. ☐ No: **see actions to be taken.**	Follow the instructions to complete this.
Do relevant staff know where to find appropriate templates for mental health treatment plans?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	See templates available here for Best Practice and Medical Director.

Description	Status	Action to be taken
Do relevant staff know what the criteria is for completing Mental Health treatment plans, Home Medication Reviews and Health Assessments through Medicare?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Refer to MBS criteria at: Mental Health treatment plans Home Medication Review Criteria Health Assessments
Does the practice have a system for tracking Medicare item number claiming?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Do GPs have access to their day sheets to identify MBS item numbers claimed? Does the practice nurse check that any assessments completed have the correct billing? Are item numbers checked against appointment diary prior to batching?
Do you know the contact details for any MBS related questions?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	Email: askMBS@health.gov.au Provider Enquiry Line - 13 21 50
Do relevant staff know that Medicare provides online training modules?	☐ Yes, continue with the activity. ☐ No, **see actions to be taken.**	More information can be obtained from Medicare Australia e-learning modules.
After reviewing the MBS claiming for patients with a mental health condition, are there any changes you would like to implement in the practice to help manage patients over the next 12 months?	☐ Yes, **see actions to be taken.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

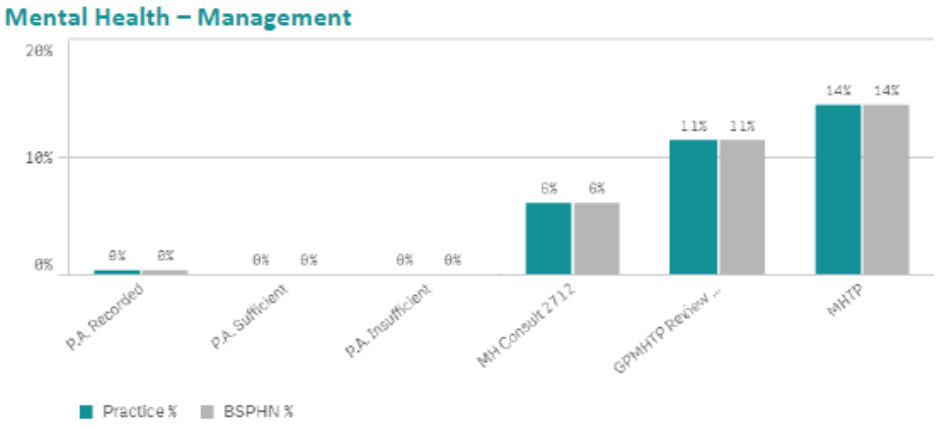
Reflection on Activity 5.1:

Practice name:	Date:
Team member:	

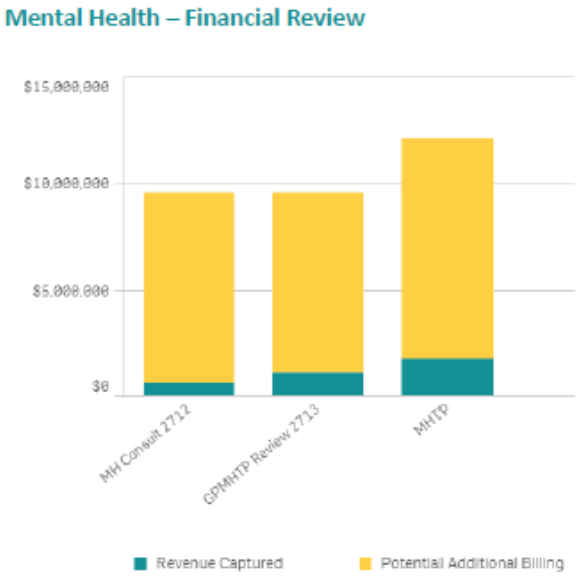
Activity 5.2 – Data collection - MBS claiming for mental health patients

The aim of this activity is to review your practice's claiming of MBS items for patients with mental health conditions.

Note – Information to complete this activity is available from your latest benchmark report from Brisbane South PHN.



Mental Health Management*	-	- %	BSPHN	BSPHN %
Active Patients with a Mental Health diagnosis**	132,420	-	132,420	-
Physical Activity Recorded	384	0%	384	0%
Physical Activity Sufficient	0	0%	0	0%
Physical Activity Insufficient	0	0%	0	0%
MHTPs (2700, 2701, 2715, 2717)***	19,084	14%	19,084	14%
MHTP review (2712)	8,069	6%	8,069	6%
Mental health consultation (2713)	15,124	11%	15,124	11%



MBS Billing Item*	Mental Health Consult (2712)	MHTP Review (2713)	MHTPs (2700, 2701, 2715, 2717)
Captured Revenue	$578,547	$1,084,391	$1,737,598
Potential Missed Revenue	$8,915,967	$8,410,123	$10,319,243

	Description	Number	Percentage
5.2a	Number of patients with a mental health condition		
5.2b	Number of patients with a mental health condition and a MH consult claimed		
5.2c	Number of patients with a mental health condition and a MH treatment plan claimed		
5.2d	Number of patients with a mental health condition and a MH treatment plan review claimed		

Reflection on Activity 5.2:

Practice name:	Date:
Team member:	

Activity 5.3– Review chronic disease management claiming for mental health patients

The aim of this activity is to review your Medicare item number claiming for patients with mental health conditions.

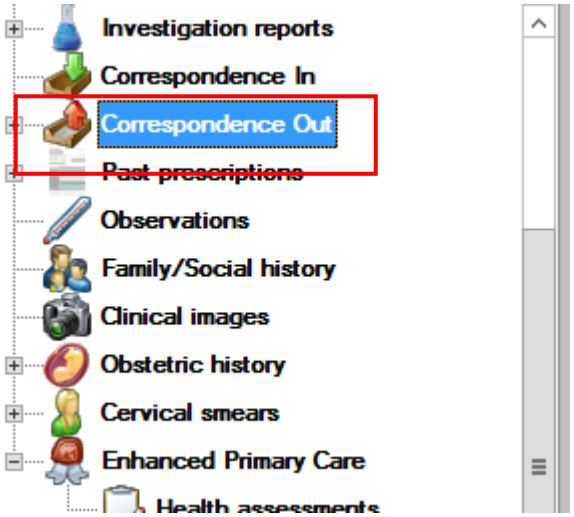
Description	Status	Action to be taken
After completing activity 5.2, are there any unexpected results with your practice's claiming for mental health patients?	☐ Yes: **see actions to be taken.** ☐ No: continue with activity.	Please explain: (*e.g. low % of patients with a MH treatment plan or we are doing well at claiming MH treatment plan reviews*). How will this information be communicated to the practice team?
Is your practice claiming for mental health patients similar to other practices in the Brisbane South region (compare information from Benchmark report)?	☐ Yes: continue with activity. ☐ No: **see actions to be taken.**	Outline the differences – *(e.g. our practice is lower at claiming mental health consultations than other practices).* How will this information be communicated to the practice team?
After reviewing your claiming for mental health patients, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes: **see actions to be taken.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 5.3:

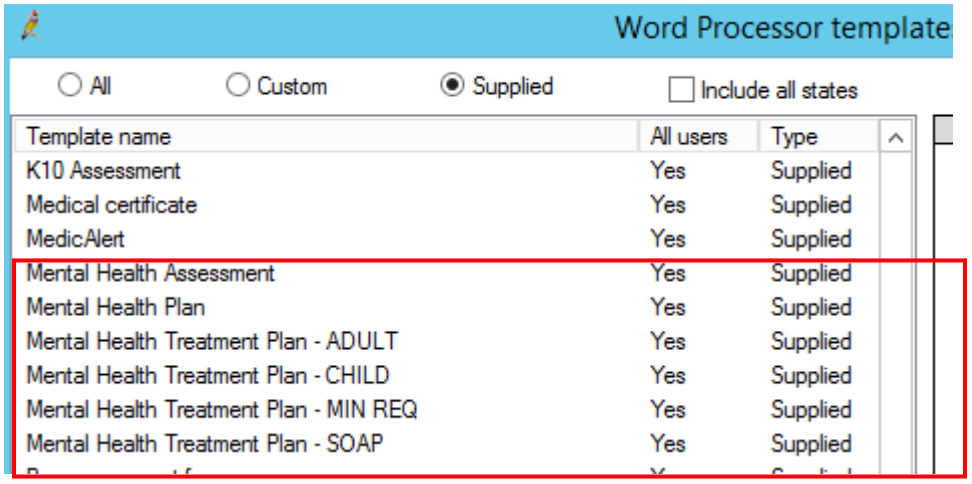
Practice name:	Date:
Team member:	

Instructions for completing mental health treatment plan in Best Practice

1. Open the patient file.



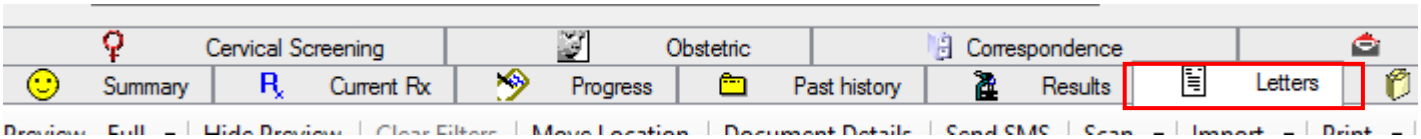
2. Select **Correspondence out.**
3. Select **Add** > **New document.**
4. You should then be able to identify and select the appropriate mental health treatment plan.



5. Complete the plan, then **Save** to complete.

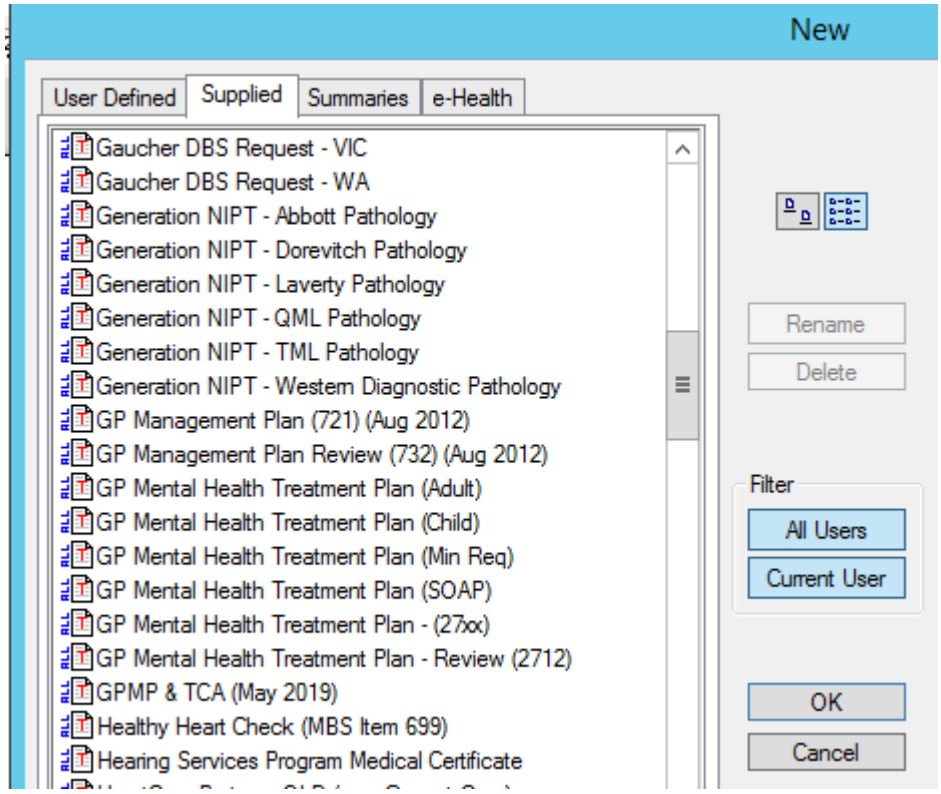
Instructions for completing mental health treatment plan in Medical Director

1. Open the patient file.
2. Select **Letters** from the menu bar.



3. Select the **+** to start a new template.

4. Then click **File** > **New.**
5. You should then be able to select **GP Mental Health Treatment Plan** (either Adult or child).
6. Complete the plan, then **Save** to complete.



Activity 6. Mental health conditions and suicide

Suicide in the Brisbane south region

The Brisbane South PHN Needs Assessment 2018 identifies mental health, suicide prevention, and alcohol and other drugs as being high contributors to poor health in Brisbane south and a priority for action for the Brisbane South PHN.[9]

During 2011-2015 suicide rates in the region were below the Queensland rates however between 2014-2015 suicide rates in the region increased.

630

From 2011-2015, there were approximately **630 deaths due to suicide** in the Brisbane South PHN region.

74%

Suicide mortality rates among males in the region were notably higher than among females, accounting for **74% of deaths by suicide** from 2011-2015.

2x

Aboriginal and Torres Strait Islander peoples experienced suicide at younger ages, and at a rate approximately **2x times** that of the non-Indigenous population.

As the first point of contact for many people, GPs and their practices are at the frontline in working with people who have considered or attempted suicide.

GPs should be alert for higher-risk individuals and the possibility of suicide.

People who are contemplating suicide will often give some clues or signs to those around them, including friends, family, colleagues, their GP or other mental health professionals.[10] Preventing suicide starts with recognising and acting on warning signs, which usually occur in combination, and being aware of the specific risk factors involved. It should be noted, however, that in some cases there might not be any warning signs.

Who is at increased risk?

A patient has increased risk of suicide if they:

- have a history of mental illness (particularly mood disorders, alcohol and drug abuse)
- have made previous suicide attempts or deliberate self-harmed
- are male
- are younger or older
- have experienced recent loss or other adverse event
- have a family history of attempted or completed suicide
- have an ATSI background
- are widowed
- live alone or in prison
- have a chronic and terminal illness
- are up to 12 months post-discharge from a psychiatric hospital
- are women experiencing intimate partner violence
- identify as LGBTQI.

[9] https://bsphn.org.au/wp-content/uploads/2019/03/Brisbane-South-Mental-Health-Suicide-Prevention-and-Alcohol-and-Other-Drug-MHSPAOD-Strategy-2019-2022.pdf

[10] https://www.healthdirect.gov.au/warning-signs-of-suicide

Suicide risk factors

For those at higher risk, it is important to be aware of and evaluate the risk factors for suicide.

- Assessment of suicide risk involves enquiring into the extent of suicidal thinking and intent. This includes assessing the following: suicidal thinking (if present, how frequent and how persistent?), planning (if present, how detailed and realistic is it?), lethality (what method has been chosen and how lethal is it?), means (does the person have the means to carry out the method?), past history (has the person ever planned or attempted suicide?), history of suicide of family member or peer.
- Also consider: guilt, impulsivity, substance use, strengths and supports
- For all people with suicidal ideation, enquiry should be made about preparatory activities e.g. obtaining a weapon, making a plan, putting affairs in order, giving away possessions, preparing a note etc.
- In young people, the HEADS ED tool has questions that can assist in assessing suicide risk.

For example:

- Sometimes when people feel really down, they feel like hurting or even killing themselves.
- They can deliberately harm or injure themselves (e.g. cutting, burning or putting them self in unsafe situations, such as unsafe sex).
- People can lose interest in things they usually enjoy.

GP involvement in suicide assessment

Research shows that quality mental health care can reduce suicidal thinking and prevent suicidal behaviour. It is important that clinicians are equipped with skills to discuss suicide and suicide risk with their patients. This involves a comprehensive psychosocial assessment and assessment of suicidality.[11]

Responding to suicide risk

It is important that clinicians are equipped to discuss and develop a suicide safety plan. Safety planning has been shown to reduce suicide risk and increase engagement with health services when used in combination with evidence-based therapy. It is important to involve the patient in treatment planning and to have a recovery-oriented focus. For people at a high and immediate risk of suicide, it is important that GPs and practice staff are aware of where to access immediate assistance if required. This may involve the local hospital or acute mental health service. Occasionally, for those at immediate danger to themselves or others, this may require calling 000 and using the Mental Health Act.

[11] https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/red-book/psychosocial/suicide

Activity 6.1– Suicide prevention in general practice

The aim of this activity is to review your practice's role in suicide prevention.

Description	Status	Action to be taken
Does your practice undertake health promotion and activities for mental health and suicide prevention?	☐ Yes: continue with activity. ☐ No: **see actions to be taken**.	Consider running a series of promotional events in the practice coinciding with World Mental Health Day.
Are clinical staff trained in how to conduct a suicide risk assessment?	☐ Yes: continue with activity. ☐ No: **see actions to be taken.**	Consider extra training in mental health first aid.
Are clinicians trained in how to develop a suicide safety plan?	☐ Yes: continue with activity. ☐ No: **see actions to be taken.**	More information available from Beyond Blue. Suicide safety planning app.
Are staff trained in how to respond to a mental health emergency?	☐ Yes: continue with activity. ☐ No: **see actions to be taken.**	Consider extra training in mental health first aid.

Description	Status	Action to be taken
Are patients provided with mental health and suicide prevention resources in other languages and for Aboriginal communities?	☐ Yes: continue with activity. ☐ No: **see actions to be taken.**	Ensure the practice has a number of mental health and suicide prevention resources available in the waiting room and GP consultation rooms. Resources available from: Head to health Beyond Blue
After reviewing your suicide prevention strategies, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes: **see actions to be taken.** ☐ No: you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 6.1:

Practice name:	Date:
Team member:	

Activity 7. Establishing appropriate care assessments and pathways using evidence-based guidelines

Activity 7.1 – Assessments to assist with identifying mental health patients

Screening tools and standardised measures are commonly used to assess patients who may be at risk of a mental health condition. They can identify motivation, dependence, mental health status, quality of life and patient risk.

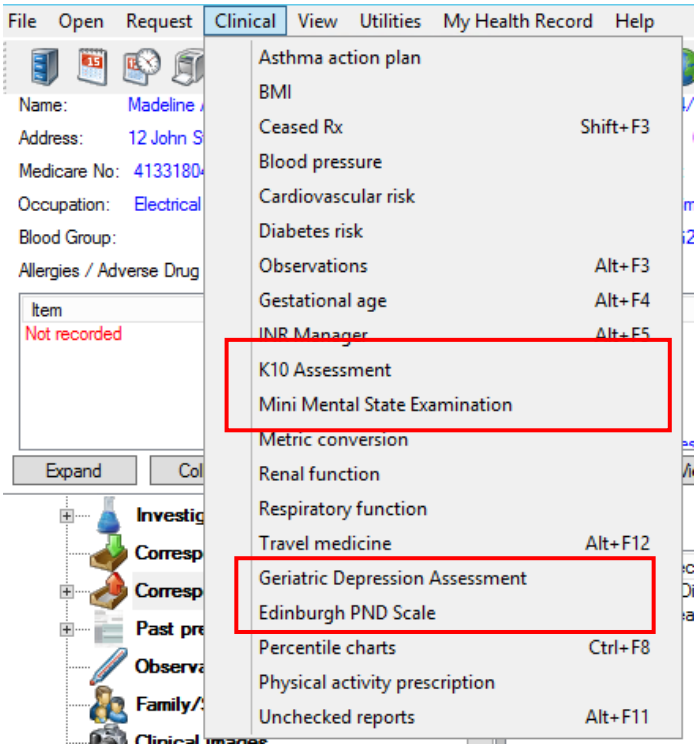
Some may also assist clinicians to effectively monitor client progress over time (outcomes). Standardised measures should supplement an assessment process, not replace it.

These screening and assessment tools are commonly used:

- Alcohol Use Disorders Identification Test (AUDIT)
- DASS 21 (Depression, Anxiety, Stress Scales)
- DASS 42 (Depression, Anxiety, Stress Scales)
- Kessler 5 (K5)
- Kessler 10 (K-10)
- Severity of Dependence Scale
- Indigenous Risk Impact Screen (IRIS)
- Substance and Choices Scale (for ages 13-18)
- Mental State Examination
- Fagerstrom Nicotine Tolerance Questionnaire
- Psycheck
- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- Edinburgh Postnatal Depression Scale
- Geriatric Depression Scale
- Montreal Cognitive Assessment
- Paediatric symptom checklist
- HEADSS – for adolescents
- HoNOS and Life skills profile

Instructions on completing screening tools on Best Practice

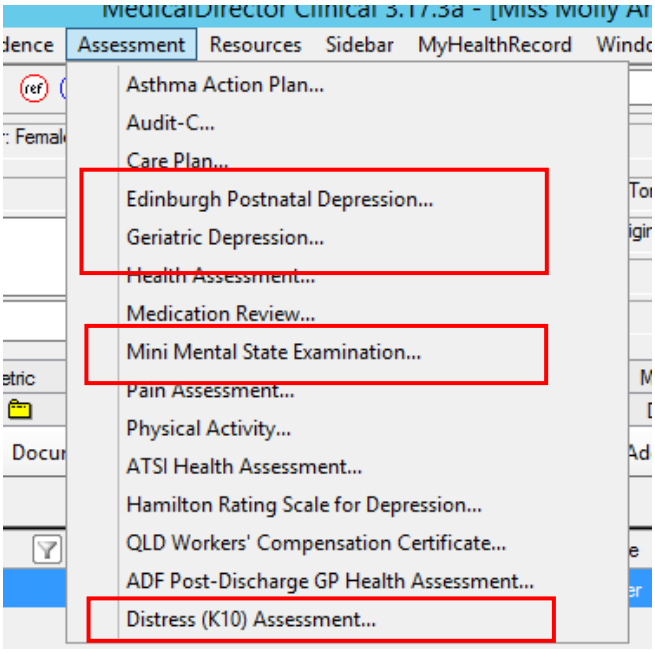
1. Open the patient file.
2. From the top menu select **Clinical.**



3. Select the appropriate assessment and complete.

Instructions on completing screening tools on Medical Director

1. Open the patient file.
2. From the top menu, select **Assessments.**



3. Select the appropriate assessment and complete.

Identify roles for managing mental health patients within your practice

Consider how best to use your practice staff to provide optimum care and the impact this will have on the workload and appointment system. This involves systematically determining if your practice is set up and equipped to provide evidence-based mental health assessment and management.

Activity	Nurse	GP
Complete appropriate screening tool (for e.g. K10 or MMSE etc).		
Organise investigations (if relevant).		
Monitor blood pressure.		
Height, weight & BMI.		
Complete cardiovascular risk assessment.		
Update patient reminders for regular monitoring (frequency depends on patients' condition).		
Review diet/healthy eating.		
Review physical activity and exercise tolerance.		
Review smoking & alcohol intake.		
Review substance and drug use.		
Offer support services.		
Provide self-care education.		
Mental health assessment.		
Consider comorbidities (CKD, diabetes, cardiovascular disease, lung cancer).		
Review medications.		
Complete mental health treatment plan and review.		
Home Medication Review (if appropriate).		
Assess need for referral to other mental health provider.		
Consider advanced care planning.		
Complete suicide risk assessment.		

Reflection on Activity 7.1:

Practice name:	Date:
Team member:	

Activity 8. Recalls and reminders

As part of the RACGP accreditation standards, it is a requirement that practices provide health promotion, illness prevention, preventive care and a reminder system based on patient need and best available evidence.

Reminders, recalls and prompts (flags)

Reminders are used to initiate prevention, before or during the patient visit. They can be either opportunistic or proactive. Recalls are a proactive follow up to a preventive or clinical activity. Prompts are usually computer generated, and designed to opportunistically draw attention during the consultation to a prevention or clinical activity needed by the patient. Using a recall system can seem complex, but there are steps you can take:

- be clear about when and how you want to use these flags
- explore systems used by other practices, your PHN, and information technology specialists to ensure you get the correct system
- identify all the people who need to be recalled and place them in a practice register to help to ensure the recall process is systematic and complete
- ensure that patient consent is obtained prior to including them in the practice reminder system

Some examples specific to mental health conditions may include: review of GP mental health plan due, medication monitoring due, depot injection due etc.

Train IT Medical – recall and reminder resources for Medical Director

Train IT Medical have a number of resources available for practices to use to assist managing their recall and reminder systems. These include:

- Sample Recall Management Protocol/FlowchartMedicalDirector learning resources
- Sample Quality Improvement Activity
- Train IT Medical 'Recalls, Reminders & Screening' using MD Presentation
- Read our MedicalDirector Clinical Top 5 'Recalls & Reminders' Tips

Train IT Medical – recall and reminder resources for Best Practice

Train IT Medical have a number of resources available for practices to use to assist managing their recall and reminder systems. These include:

- Reminders quick reference guide
- Creating a reminder template
- Sending SMS reminders to patients
- Recall & reminders – why it's so hard

Activity 8.1 – Reminder system

<table>
<tr><th></th><th colspan="2">Status</th><th>Action to be taken</th></tr>
<tr><td>Does your practice have a routine reminder for appropriate mental health follow up?</td><td colspan="2">☐ Yes, continue with activity.

☐ No, see action to be taken.</td><td>For instructions on creating a reminder in Best Practice.

For instructions on creating a reminder in Medical Director.</td></tr>
<tr><td>Is consent obtained from patients to be included in the practice's reminder system?</td><td colspan="2">☐ Yes, how is this done?

☐ No, see action to be taken.</td><td>Include a section on new patient information sheet about consent to participate in reminder system.

Clinicians ask patients prior to placing them on reminder system.</td></tr>
<tr><td>How does the practice record if a patient DOES NOT wish to be contacted offering reminder appointments?</td><td colspan="3"></td></tr>
<tr><td>Do clinicians know how to initiate a patient reminder within clinical software?</td><td colspan="2">☐ Yes, continue with activity.

☐ No, see action to be taken.</td><td>Clinician education on setting up patient reminders.</td></tr>
<tr><td rowspan="2">How regularly are reminder lists generated for each doctor/nurse?</td><td>Doctor</td><td>Practice nurse</td><td rowspan="2">Create a practice policy for frequency of generating lists.

Nominate a practice member to generate reminder lists.</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Is there a system for reviewing and actioning reminder lists? i.e.

• all posted
• all telephoned
• wait for patient to attend
• GPs review lists and classifies reminders.</td><td colspan="2">☐ Yes, continue with activity.

☐ No, see action to be taken.</td><td>Create policy for activating reminders due.

Nominate a practice member to activate reminders due.</td></tr>
<tr><td>Is there a system to identify in the appointment book when a patient is coming in for a reminder appointment?</td><td colspan="2">☐ Yes, continue with activity.

☐ No, see action to be taken.</td><td>Use of a symbol in the appointment book to identify type of appointment.</td></tr>
</table>

	Status	Action to be taken
Is there a process for acting on or removing outstanding reminders? E.g. patients fail to attend, reminder no longer needed.	☐ Yes, continue with activity. ☐ No, **see action to be taken.**	GP education on removing reminders. Document practice process on removing reminders.
Is there a practice policy on how reminders are to be implemented? E.g. *entering all reminders for the upcoming 12 months to ensure all tests are performed*?	☐ Yes, policy is working. ☐ Yes, policy is not working, see action to be taken. ☐ No policy, **see action to be taken.**	Revise policy. Practice policy on reminders to be implemented.
Is there a system for ensuring patients recently diagnosed with a mental health condition are incorporated into the reminder system?	☐ Yes, policy is working. ☐ Yes, policy is not working, see action to be taken. ☐ No policy, **see action to be taken.**	Revise policy. Practice policy on reminders to be implemented.
After reviewing your practice recall and reminder system, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, **see actions to be taken.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

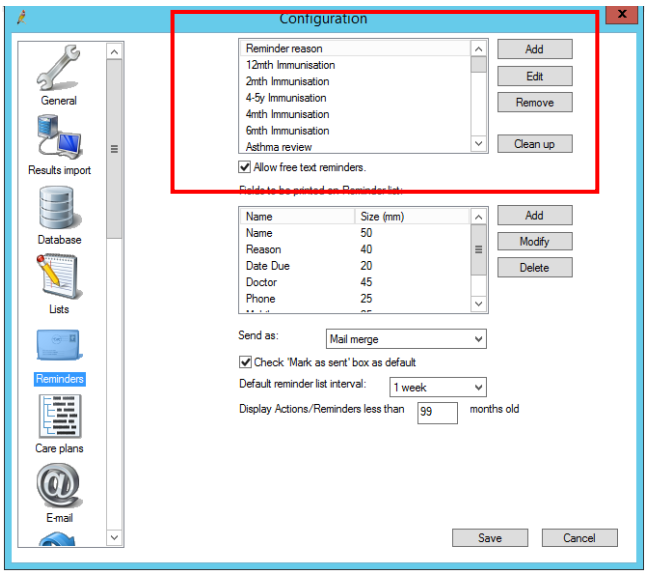
Reflection on Activity 8.1:

Practice name:	Date:
Team member:	

Creating reminder category for monitoring mental health in Best Practice

To create a reminder category for monitoring patients with mental health in Best Practice: (*please note: always check the reminder list prior to creating a category as it may already be included)*

1. Select **Setup > Configuration** from the main Best Practice screen.
2. Scroll down on the left-hand side to find the Reminders icon.
3. The top section of the screen shows the Reminder Reason list—this is the full list of reminder reasons available when reminders are being created within the patient record.
4. Choose **Add.**

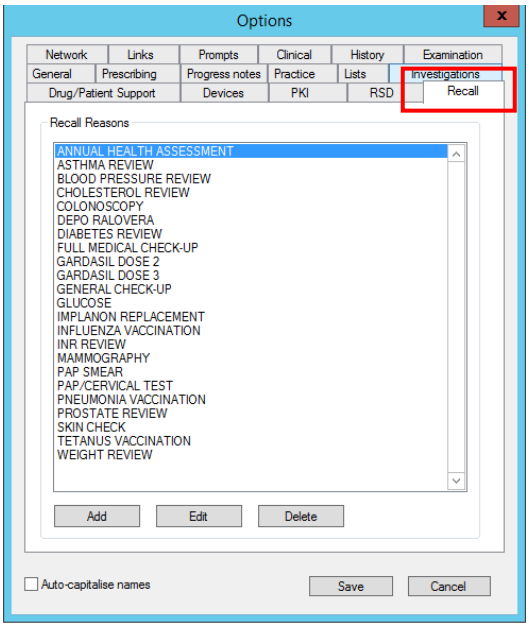


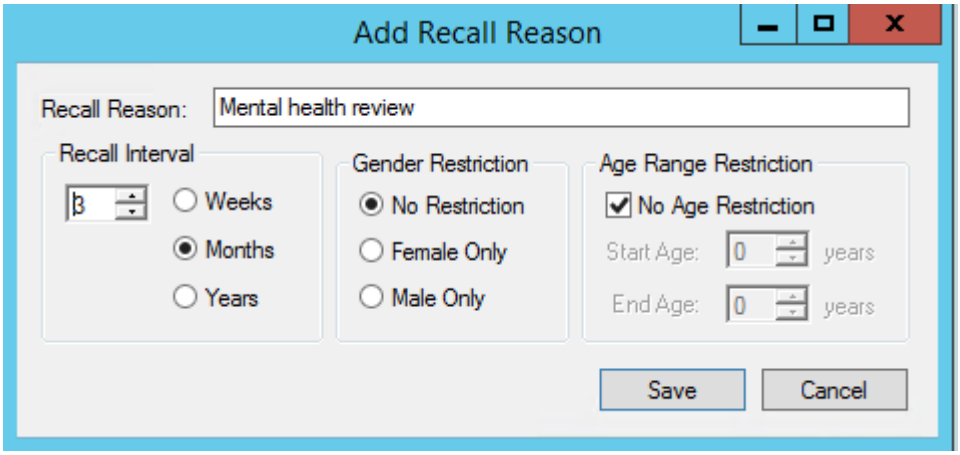
5. Type in the reason as appropriate (e.g. mental health review) and then the interval.
6. Click **Save** > **Save**

Creating reminder category for monitoring mental health in Medical Director

To create a reminder category for monitoring mental health patients in Medical Director: (*please note: always check the reminder list prior to creating a category as it may already be included)*

1. Select **Tools > Options**.
2. Select the **Recall tab**. The list of recall reasons is presented.
3. Select **Add.**
4. Enter a **Name/description** for the recall reason you wish to add.
5. Modify other settings as desired: note that these settings are simply the defaults for this recall reason, which can be overridden when you go to create a new recall for the patient.





- **Recall Interval:** How often the recall should occur, when it is used for recurring recalls (as opposed to once-off recalls)
- **Gender Restriction**: Whether the recall reason's availability is limited to a specific gender
- **Age Range Restriction:** Whether the recall reason's availability is limited to a specific age group.

6. Click **Save** to confirm. You will be returned to the **Recall tab**, where your new recall reason is now listed.

Activity 9. Referral pathways

The aim of this activity is to ensure that practice staff have access to the relevant information and understand pathways for referral of patients to specialists and allied health staff as deemed clinically appropriate.

Engaging other medical services (e.g. diagnostic services; hospitals and consultants; allied health; and social, disability, financial, housing, training, supported employment, alcohol and drug treatment and community services) assist the practice to provide optimal care to patients whose health needs require integration with other services.

Multidisciplinary teams convey many benefits to both service users and the mental health professionals working on the team, such as continuity of care, the ability to take a comprehensive, holistic view of the service user's needs, the availability of a range of skills, and mutual support and education.[12]

Potential members of the multidisciplinary mental health team

12 https://www.researchgate.net/publication/260125071_Interdisciplinary_Care_to_Enhance_Mental_Health_and_Social_and_Emotional_Wellbeing

Essential referral information for mental health patients

Metro South 24-hour phone support

The Metro South community can access local mental health services for information and assistance in times of mental health crisis 24 hours a day via a centralised phone number:

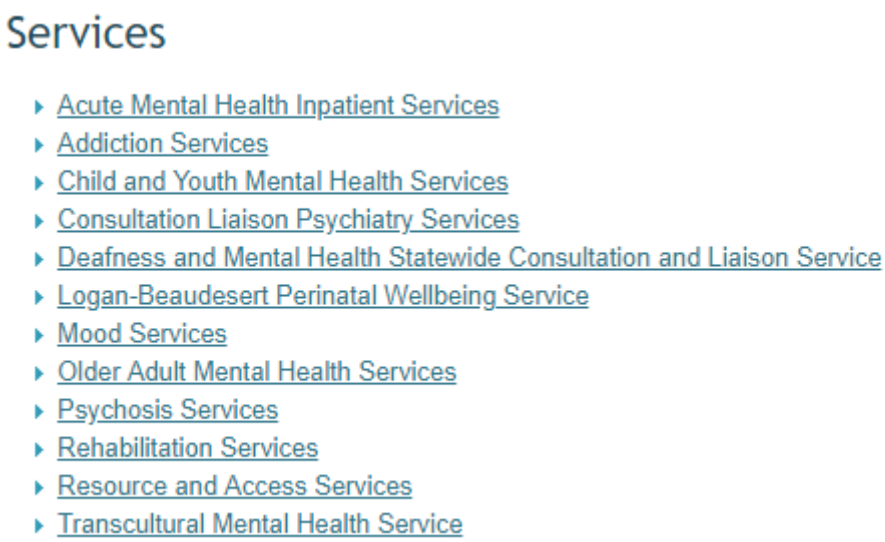
Phone: 1300 MH CALL (1300 64 22 55)

Refer your patient

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

The website outlines available health professionals, criteria to access appointments with the health professionals and expected wait times as well as all the information required in the referral.

Metro South Health provides a number of services to patients with a variety of mental health conditions.



Under each section, referral requirements are listed to assist with the smooth transition of care. This is an example of the requirements of older people mental health:

Referrals

To ensure your service needs are met in a timely manner we would request the following information at time of referral:

- Self or carer referrals: Our triage clinicians will guide you through any additional information that may be required. It is essential to know about active Guardianship or Power of Attorney arrangements.
- For health practitioners: Key assessment findings, treatment interventions provided or proposed, and current General Practitioner/other service providers.
- For General Practitioners: Key assessment findings including physical examination and current medications. Suggested pathology ELFT, FBE, TSH MSU, serum levels of medication (if applicable) and cognitive test scores and neuroimaging (if relevant).
- For residential aged care facilities: General Practitioner review prior to referral (see GP requirements above), Psychogeriatric Assessment Scale (PS), Neuropsychiatric Inventory (NPI) and Cornell Scale for Depression results if available.
- Emergency services (Ambulance or Emergency Departments): These services can facilitate access for individuals in an acute crisis.
- What if the person won't agree to be seen? The *Mental Health Act 2016* provides for the involuntary assessment and treatment, and the protection, of persons with mental illness. Our triage service can advise you about this.

More information about referral criteria can be found at Metro South Health

SpotOnHealth HealthPathways

SpotOnHealth HealthPathways provides clinicians in the greater Brisbane south catchment with web-based information outlining the assessment, management and referral to other clinicians for more than 550 conditions.

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

To access SpotOnHealth HealthPathways you will need to log in.

Primary mental health and wellbeing initiatives

Brisbane South PHN commissions mental health, suicide prevention, and alcohol and other drug services designed to provide flexible support that is best suited to an individual's needs. There are three sub-regions:

- Brisbane (Princess Alexandra Hospital catchment area)
- Logan/Beaudesert (Logan Hospital catchment area)
- Redlands (Redlands Hospital catchment area)

Assistance is available for GPs to link to Brisbane South PHN commissioned mental health services.

Health Services Directory

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

My Community Directory

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

Other services

If you can't find a service that suits your needs, these links may help:

- Alcohol and Drug Information Service
- Ask Izzy
- Head to Health
- Lifeline
- Metro South Health
- Suicide Call Back Service

Activity 9.1 – Referral Pathways

Complete the checklist below in relation to referral pathways.

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

	Status	Action to be taken
Do all GPs and Nurses have login details for SpotOnHealth HealthPathways?	☐ Yes, continue with the activity. ☐ No, see **Action to be taken.**	Register on the login page to request access.
Do all GPs and Nurses know how to access SpotOnHealth HealthPathways via Topbar?	☐ Yes, continue with the activity. ☐ No, see **Action to be taken.**	See instructions. Or contact BSPHN Digital Health Team via email: ehealth@bsphn.org.au.

	Status	Action to be taken
Do all GPs and Nurses know how to refer to Brisbane South PHN commissioned mental health, suicide prevention and alcohol and other drug services?	☐ Yes, continue with the activity. ☐ No, see **Action to be taken.**	Refer to Brisbane South PHN. Refer to the FAQs page.
How will you communicate information so clinicians know where to access details on referring a patient to specialist services?	What is the practice plan for communicating referral information?	
After reviewing your practice referral system, are there any changes you would like to implement in the practice, to help manage patients, over the next 12 months?	☐ Yes, see **actions to be taken.** ☐ No, you have completed this activity.	Refer to the Model for Improvement (MFI) and the Thinking part at the end of this document. Refer to the Doing part - PDSA of the Model for Improvement (MFI) to test and measure your ideas for success.

Reflection on Activity 9.1:

Practice name:	Date:
Team member:	

Activity 10. Policy and procedures (including mental health strategies)

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

- anti-bullying in the workplace
- support for staff when dealing with stressful situations
- dealing with difficult patients
- GP self-care
- transfer of patient care
- personal duress alarms
- employee assistance program
- patient's rights and responsibilities
- mental health first aid
- triage – includes suicidal patients or those who have self-harmed

Activity 10.1 – Policies and Procedures

*Complete the below table to gather information on your **current** policies and procedures relating to mental health management.*

Activity 10.1 – Review Policy & Procedures				
Does the practice have a policy and procedure for the following?	**Policy up to date ***	**Policy needs reviewing**	**Who will review or update?**	**Date completed**
Anti-bulling in the workplace	☐	☐		
Support for staff when dealing with stressful situations	☐	☐		
Dealing with difficult patients	☐	☐		
GP self-care (http://www.dhas.org.au/)	☐	☐		
Transfer of patient care	☐	☐		
Personal duress alarms	☐	☐		
Employee assistance programs	☐	☐		
Patient's rights and responsibilities	☐	☐		
Mental Health first aid	☐	☐		
Triage – including suicidal or patients who have self-harmed	☐	☐		
Workplace and safety	☐	☐		

Reflection on Activity 10.1:

Practice name:	Date:
Team member:	

Activity 10.2 – Policies and procedures review

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

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

Reflection on Activity 10.2:

Practice name:	Date:
Team member:	

Activity 11. Resources and education

Mental health resources for health professionals

- Mental health guidelines - RACGP
- Keeping body and mind together – RANZCP
- Clinical Guidelines for the Physical Care of Mental Health Consumers
- Headspace clinical toolkit
- Diagnostic and Statistical Manual of Mental Disorders, 5th edition – American Psychiatric association
- SpotOnHealth HealthPathways

Education for health professionals

- Mental health skills training – ThinkGP
- Insight training
- Mental health CPD for nurses
- RACGP e-learning modules
- Brisbane South PHN Education events
- National Prescribing Service - You can find a number of resources focused on mental health conditions. Specific resources of interest to health professionals may include:
  - MedicineWise News
  - Clinical eAudit
  - Online case study
- Mental health first aid – there are a number of accredited courses available to complete this
- Managing Physical Health in Severe Mental Illness - RACGP

Resources for patients

- Sane Australia
- Beyond Blue
- Black Dog Institute
- Lifeline
- Suicide Call Back Service
- Head to health
- Alcohol and Drug information services

Resources for Aboriginal and Torres Strait Islander patients

- Family support and healing -Queensland health
- Beyond Blue
- Head to health

Quality improvement activities using the model for improvement and PDSA

After completing any of the workbook activities above you may identify areas for improvement in the management of patients with a mental health condition. Follow these steps to conduct a quality improvement activity using The Model for Improvement and PDSA. The model consists of two parts that are of equal importance.

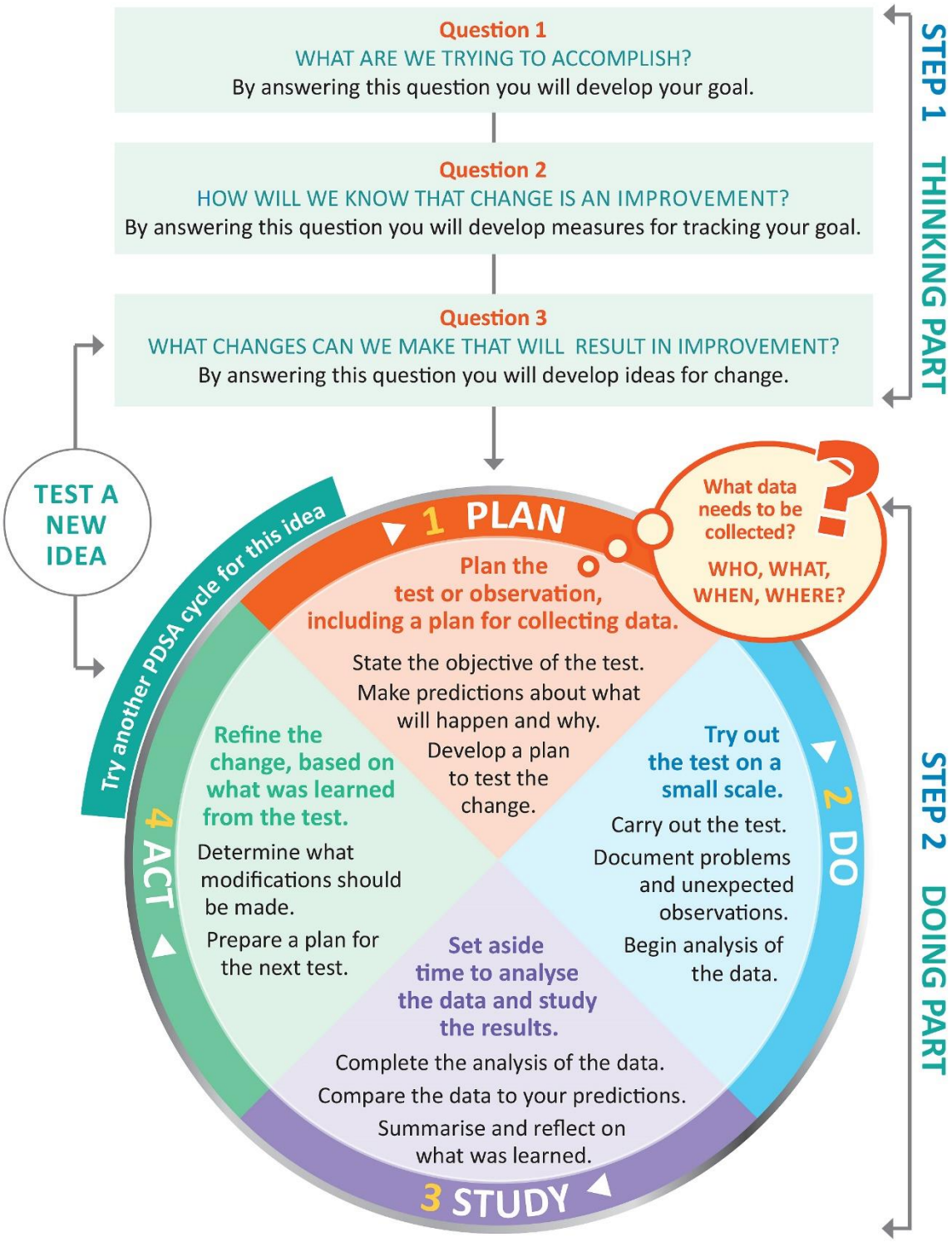
Step 1: The **'thinking'** part consists of three fundamental questions that are essential for guiding improvement work:

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

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

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

The model for improvement diagram



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

Model for improvement and PDSA worksheet EXAMPLE

Step 1: The Thinking Part - The 3 Fundamental Questions

Practice name:	Date:
Team member:	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your goal for improvement

Our goal is to:

- Ensure all patients with a mental health diagnosis have their alcohol consumption recorded.

This is a good start, but how will you measure whether you have achieved this goal? The team will be more likely to embrace change if the goal is more specific and has a time limit.

So, for this example, a better goal statement would be:

Our S.M.A.R.T. goal is to:

- Increase the percentage of alcohol consumption recorded on all active patients aged 15 years and older with an active mental health condition by 10% by 31 July.

Q2. How will you know that a change is an improvement? (Measure)

By answering this question, you will develop MEASURES to track the achievement of your goal.
E.g. Track baseline measurement and compare results at the end of the improvement.

We will measure the percentage of active patients who have their alcohol consumption recorded. To do this we will:

A) Identify the number of active patients aged 15 years and older with an active mental health condition.

B) Identify the number of active patients aged 15 years and older who have had their alcohol consumption recorded.

B divided by A x 100 produces the percentage of patients who have had their alcohol consumption recorded.

Q3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal.
You may wish to BRAINSTORM ideas with members of our practice team.

Our ideas for change:

1. Using CAT4, identify active patients aged 15 years and older who have not had alcohol consumption recorded.
2. Identify patients from list exported from CAT4 and create a TopBar prompt.
3. Source and provide endorsed patient education resources (in waiting rooms, etc).

The team selects one idea to begin testing with a PDSA cycle.

Note: Each new GOAL (1st Fundamental Question) will require a new Model for Improvement Guide

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA.

Model for Improvement and PDSA worksheet EXAMPLE

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

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

PLAN	Describe the brainstorm idea you are planning to work on. (Idea)
Plan the test, including a plan for collecting data	*What exactly will you do? Include what, who, when, where, predictions and data to be collected.*
Idea: Using CAT4, identify active patients aged 15 years and older with an active mental health condition who have not had their alcohol consumption recorded. What: Mary will conduct a search on CAT4. Who: Receptionist (Mary) When: Begin 20 May Where: at the practice in Dr Brown's room Prediction: 40% of the active patient population with a mental health condition aged 15 years and older will have an alcohol consumption recorded. Data to be collected: Number of active patients 15 years and older with an active mental health condition and the number of active patients 15 years and older who have not had an alcohol consumption recorded.	
DO	**Who is going to do what? (Action)**
Run the test on a small scale	*How will you measure the outcome of your change?*
Completed 20 May – the receptionist contacted Brisbane South PHN for support with the PenCS CAT4 search and the export function. The data search was conducted very quickly, with the receptionist being upskilled to conduct further relevant searches.	
STUDY	**Does the data show a change? (Reflection)**
Analyse the results and compare them to your predictions	*Was the plan executed successfully?* *Did you encounter any problems or difficulty?*
A total of 327 active patients (37%) 15 years and older have had their alcohol consumption recorded = 3% lower than predicted.	
ACT	**Do you need to make changes to your original plan? (What next)** **OR Did everything go well?**
Based on what you learned from the test, plan for your next step	*If this idea was successful you may like to implement this change on a larger scale or try something new.* *If the idea did not meet its overall goal, consider why not and identify what can be done to improve performance.*

1. Create a PenCS Topbar prompt to ensure all patients aged 15 years and older with an active mental health condition to have alcohol consumption recorded. Review this by 31 July (in 2 months' time) to determine if there has been an increase in the % of patients recorded.
2. Ensure the clinical team know how to enter alcohol consumption in the medical software.
3. Remind the whole team that this is an area of focus for the practice.

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

Model for Improvement and PDSA worksheet template

Step 1: The Thinking Part - The 3 Fundamental Questions

Practice name:	Date:
Team member:	

Q1. What are we trying to accomplish? (Goal)

By answering this question, you will develop your GOAL for improvement.

Q2. How will you know that a change is an improvement? (Measure)

By answering this question, you will develop MEASURES to track the achievement of your goal.

E.g. Track baseline measurement and compare results at the end of the improvement.

3. What changes could we make that will lead to an improvement? (List your IDEAS)

By answering this question, you will develop the IDEAS that you can test to achieve your CHANGE goal.

You may wish to BRAINSTORM ideas with members of our Practice Team.

Idea:

Idea:

Idea:

Idea:

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

Model for Improvement and PDSA worksheet template

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

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

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

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

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