



# Collaborative Care Checklist



## Purpose

This resource can be used as a checklist for improving collaborative care with multidisciplinary teams in primary care settings to support management of chronic conditions, mental health and in aged care.

To ensure patient-centred care remains at the heart of primary care, multidisciplinary collaboration led by the general practice is key. Successful team-based care delivery models is enabled by general practice leadership in responding to change, adapting team roles and workflows<sup>1</sup>.

The [Multidisciplinary collaboration | Australian Commission on Safety and Quality in Health Care](#) defines the principles of collaborative care as:

- ☒ Person-centred care: Patients and families are active partners.
- ☒ Shared goals and accountability: All team members work toward common objectives.
- ☒ Clear roles and responsibilities: Avoid duplication and gaps.
- ☒ Effective communication: Structured handover and shared records.
- ☒ Cultural safety: Especially for Aboriginal and Torres Strait Islander peoples

## What you can bring to the team

There are five principles of teamwork and collaboration in healthcare that continue to build on your effective team culture<sup>2</sup>. Is your practice embedding these? What improvements could be made?

- ☒ Shared goals
- ☒ Clear roles
- ☒ Mutual trust
- ☒ Effective communication
- ☒ Measurable processes and outcomes

## Teamwork Enablers

Teamwork and collaboration - Trust and team culture are built through regular meetings and joint decision-making. Are you incorporating these opportunities for teamwork?

- ☒ **Regular team huddle/ meetings** to discuss priority patients, progress actions and escalate risks.
- ☒ **Trust and team culture:** Built through regular meetings, collaboration and joint decision-making.
- ☒ **Workforce & roles:** Consider roles within the team and the strengths of each team member, e.g. Practice nurses for coordination and recalls; practice pharmacists for medicines optimisation; care coordinators/Nurse Navigators for complex transitions.
- ☒ **Document team members tasks** within patient care plans with due dates and responsible team members.
- ☒ **Document workflows and standing orders** to enable all team members to be on the same page with patient care even when all team members are not present.

## System Enablers

Leveraging the available systems and incentives will support and build teamwork in your practice.

- ✓ **MyMedicare:** Registering in [MyMedicare](#) enhances the patient-practice relationship, formalising a connection between the patient and their health care team.
- ✓ **Billing, funding and incentives:** Use MBS items for care plans and case conferencing. Use [GP Chronic Condition Management Plan/ Mental Health Treatment Plan](#) items for structured care; time-tiered MBS [case conferencing](#) for organising/participating in team-based care; apply permanent MBS telehealth appropriately; and leverage [PIP QI](#) and [MyMedicare](#) incentives.
- ✓ **Organisational systems:** Policies for [governance](#) and coordination with support services (e.g. after hours).
- ✓ **Collaborate with your [local PHN](#)** for QI activities.
- ✓ **Digital infrastructure:** [My Health Record](#) (Shared Health Summary/Event Summary); secure messaging (SMD) with [NASH certificates](#); [HealthPathways access and training](#).
- ✓ **Governance & safety:** Align to [RACGP Standards and National Safety & Quality Primary & Community Healthcare Standards](#); [RACGP guidance for electronic sharing](#).

## Collaboration Models you can adopt

- ✓ **Case Conferencing**
  - Structured collaboration (MBS items available GPs, allied health and mental health professionals). [Requirements of care plans and case conferences - Health professionals - Services Australia](#)
- ✓ **Shared medical appointments**

Shared medical appointments are where a cohort of patients with similar health concerns attend appointments together to receive education and clinical advice. [RACGP - Shared medical appointments](#)
- ✓ **General Practice in Aged Care Incentive**
  - Collaboration between primary care providers and aged care to improve continuity of care and care planning with allied health and pharmacy +/- other specialists for the patient's ongoing care. [General Practice in Aged Care Incentive | Australian Government Department of Health, Disability and Ageing](#)
- ✓ **Aboriginal Community Controlled Health Service (ACCHS) model**
  - Culturally safe, comprehensive, community-led care with multidisciplinary teams (GPs, Aboriginal Health Practitioners/Workers, nurses, allied health, social supports). [Aboriginal Community Controlled Health Organisations - NACCHO](#)
- ✓ **Health Pathways-enabled Virtual Multidisciplinary Teams**
  - Practice team uses local HealthPathways for evidence-informed assessment/management, referral criteria and patient resources; co-developed by local GPs and specialists. [HealthPathways](#)  
[What is a virtual multidisciplinary team \(vMDT\)? - PMC](#)  
[Multidisciplinary services | Living well in multi-purpose services | Agency for Clinical Innovation](#)
- ✓ **GP-led Patient-Centred Medical Home**
  - Usual GP + practice nurse + in-practice/partnered allied health; team huddles; proactive registers; shared care plans; telehealth follow-ups.
  - Variation: add a non-dispensing practice pharmacist to lead medicines optimisation and audits. [Key Principles of Patient Centred Medical Homes | Navigating the Healthcare Neighbourhood](#)

## Resources and Tools

- Clinical Handover [Ossie Guide to Clinical Handover Improvement | Australian Commission on Safety and Quality in Health Care](#)
- ISBAR: figure 2 - [RACGP - Collaboration and multidisciplinary team-based care](#)
- Effective communication - [Effective Communication For Multidisciplinary Teams](#)
- [Primary Care – RACH Coordination Toolkit](#) – A resource to support partnerships between Residential Aged Care Homes and Primary Care
- Allied Health engagement framework for PHNs [National-Allied-Health-Practice-Engagement-Toolkit-Final.pdf](#)
- Multidisciplinary collaboration [Multidisciplinary collaboration | Australian Commission on Safety and Quality in Health Care](#)
- Communication Between Providers and Allied Health Professionals [ACIA 013 Communication between Providers and Allied Health Professionals.pdf](#)

## Examples in Practice

- Snowy SMA model - [Case study – Snowy Valleys shared medical appointment model | Australian Government Department of Health, Disability and Ageing](#)
- Aged Care - [Scoping study on multidisciplinary models of care in residential aged care homes – Summary](#)
- Rural /Remote - [Innovative Models of Care \(IMOC\) Program | Australian Government Department of Health, Disability and Ageing](#)
- Engagement models for PHNs - [Allied Health Engagement Model](#) – Murray PHN

## Further Reading

### MBS online

- [Multidisciplinary Case Conferences by Primary Care Medical Practitioners \(MBS items 235, 236, 237, 238, 239, 240, 735, 739, 743, 747, 750 and 758\)](#)
- [Mental Health Case Conference \(Associated Items: 930, 933, 935, 937, 943, 945, 946, 948, 959, 961, 962, 964, 969, 971, 972, 973, 975, 986, 80176, 80177, 80178\)](#)

### Mental health Case Conferencing

- [PDF - Mental Health Case Conferencing.pdf](#)

### Tips for Nurses: Case Conferences

- [Tips for nurses: Case conferences](#)

### **Link to case conferencing guide**

### Interprofessional collaboration: three best practice models of interprofessional education

[Interprofessional collaboration: three best practice models of interprofessional education - PMC](#)

### Footnote references

- 1 - [Implementing team-based primary care models: a mixed-methods comparative case study in a large, integrated health care system - PMC](#)
- 2 - [RACGP - Collaboration and multidisciplinary team-based care](#)