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The Pharmacy Guild of Australia

5th Community Pharmacy Agreement

Professional Collaboration

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Research & Development

FULL FINAL REPORT

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Acronyms and abbreviations

Abbreviation	Description
2CPA	2nd Community Pharmacy Agreement
4CPA	4th Community Pharmacy Agreement
5CPA	5th Community Pharmacy Agreement
ABS	Australian Bureau of Statistics
ACQHS	Australian Commission on Safety and Quality in Health
ADE	Adverse Drug Event
AHMC	Australian Health Ministers' Conference
AHPRA	Australian Healthcare Provider Registration Authority
AHW	Aboriginal Health Worker
ALos	Average Length of Stay
AMA	Australian Medical Association
AMLA	Australian Medicare Local Alliance
AMS	Aboriginal Medical Services
ANF	Australian Nursing Federation
ANPHA	Australian National Preventative Health Agency
CEO	Chief Executive Officer
CHF	Consumer Health Forum of Australia
Consumer	The collective term used for consumers, consumers and clients utilising primary health care services
COPD	Chronic Obstructive Pulmonary Disease
CWR	Collaborative Working Relationships Model
DoHA	Australian Government Department of Health and Ageing
DMAS	Diabetes Medication Assistance Service
ED	Emergency Department
EICP	Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative
FIP	The International Pharmaceutical Federation
GP	General Practitioner; the collective term used for doctors/physicians who are the main prescriber of medicines
HACC	Home and Community Care
HITH	Hospital In The Home

Abbreviation	Description
HMR	Home Medicines Reviews
HWA	Health Workforce Australia
LoS	Length of stay
LHN	Local Hospital Networks
MBS	Medical Benefits Schedule
NEHTA	National eHealth Transition Authority
NGO	Non Government Organisation
NHPA	National Health Performance Authority
NPS	National Prescribing Service
PBS	Pharmaceutical Benefits Scheme
PCEHR	Personally Controlled Electronic Health Record
PHO	Primary Health Organisations
PIR	Partners in Recovery
PPI	Pharmacy Practice Incentives
PSA	The Pharmaceutical Society of Australia
QUM	Quality Use of Medicines
QUMAX	Quality Use of Medicines Maximised
RMMR	Residential Medication Management Review
TGA	Therapeutic Goods Administration
The Guild	The Pharmacy Guild of Australia
UK	The United Kingdom
USA/US	The United States of America (noun/adjective)
UTI	Urinary Tract Infections
WHO	The World Health Organization

Definitions

Community pharmacists

Community pharmacists are medicine experts, providing professional advice and counselling on medications, including their use and effects, as well as general health care. Their services are highly accessible – in the vast majority of cases, these services are offered to consumers free of charge and without the need to make an appointment. Community pharmacists are the custodians of the Pharmaceutical Benefits Scheme (PBS) and play a vital role in the primary health care of all Australians. Pharmacists are professionally and legally accountable for every piece of advice and service provided in their pharmacies. Their continuing registration and approval to dispense medications under the PBS depends on them always being present in the pharmacy and abiding by the rules of the Pharmacy Boards in the various States and Territories (Pharmacy Guild of Australia, 2009).

Consumer-centred care

A 'consumer-centred' model draws on the values of the World Health Organization definition of 'person-centred health care' (2006). These values include empowerment, participation, access and the central role of family and community. This means that people have the right and duty to participate in making decisions about their health care, not only regarding treatment and management, but also for broader issues of health care planning and implementation. DoHA has articulated this as 'a primary health care system which is designed around supporting the individual, their family and carers to be in control and actively supported in their care. It is also about a system which is easy for them to access the care they need and which helps them to manage their health care needs and stay as healthy as possible' (Australian Government Department of Health and Ageing, 2009).

General Practice

General practice provides person centred, continuing, comprehensive and coordinated whole of person health care to individuals and families in their communities. As a sector, general practice, its practice teams and their primary health care relationships comprise the foundations of an effective health care system (The Royal Australian College of General Practitioners, nd).

Health care

Healthcare (or health care) is the maintenance and improvement of physical and mental health, especially through the provision of medical services (Oxford Dictionary, nd). While these two terms have the same meaning, 'health care' has been utilised in this report.

Interdisciplinary approaches

Interdisciplinary team approaches integrate separate discipline approaches into a single consultation. The patient is intimately involved in any discussions regarding their condition or prognosis and the plans about their care. A common understanding and holistic view of all aspects of the patient's care ensues, with the patient empowered to form part of the decision-making process, including the setting of long and short-term goals. Individuals from different disciplines, as well as the patient themself, are encouraged to question each other and explore alternate avenues, stepping out of discipline silos to work toward the best outcome for the patient (Jessup, 2007).

Multidisciplinary approaches

Multidisciplinary team approaches utilise the skills and experience of individuals from different disciplines, with each discipline approaching the patient from their own perspective. Most often, this approach involves separate individual consultations. It is common for multidisciplinary teams to meet regularly, in the absence of the patient, to "case conference" findings and discuss future directions for the patient's care. Multidisciplinary teams provide more knowledge and experience than disciplines operating in isolation (Jessup, 2007).

Primary health care setting

Primary health care is understood to be 'the care provided at the first level of contact with the health care system, the point at which health services are mobilized and coordinated to promote health, prevent illness, care for common illness, and manage health problems' (National Forum on Health, Canada Health Action: Building on the legacy. The final report of the National Forum on Health. Ottawa: Health Canada Communications, 1997, p.22).

Professional collaboration

The World Health Organization defines collaborative practice in health as 'occurring when multiple health workers provide comprehensive services by working together synergistically along with consumers, their families, carers and communities to deliver the highest quality care across settings' (World Health Organization Health Professions Networks Nursing and Midwifery Human Resources for Health, Framework for Action on Inter-professional Education and Collaborative Practice, 2009).

Executive summary

A strong and integrated primary health care sector is key to achieving healthy communities. Current primary health care reforms in Australia are aimed at a more effective health care system through better coordination (Australian Government Department of Health and Ageing, 2010). The success of these reforms will require better professional collaboration among primary health care professionals.

The *Professional Collaboration* project ('the project')[1] aimed to identify a model of best practice for collaboration between community pharmacists and other health professionals in the Australian primary health care setting that will bring positive benefits to the health care system and consumers.[2] Research suggests that a lack of collaboration and communication can result in patient-related adverse events such as unexpected side effects and interactions of medicines, creating costly and avoidable pressure on the hospital system, as well as inefficiency in the primary health care system through duplication of services.

- The findings of the project were complex and mostly interdependent:
- Policy and strategic oversight – There is currently a lack of a shared vision for primary health care between professional groups, both at a national and regional level (e.g. Medicare Locals). Effective leadership and support for collaboration across organisations at the national and regional levels was identified as a key way to enable professional collaboration.
- Governance – Many health professional peak bodies operate independently and in isolation from each other without a shared vision for collaboration. Similarly, at an individual level, not all health professionals share the same understanding of the potential benefits of collaboration.
- Funding – Under the current model, general practitioners (GPs), specialists and pharmacists are reimbursed for their services under the Medicare Benefits Scheme and Pharmaceutical Benefits Scheme. This current fee-for-service funding model was often cited as a key barrier to collaboration as it provides no incentive to health professionals to participate in collaborative efforts outside of their time spent with the consumer.
- Measures – Data on collaborative practice is rarely collected and there is currently no standardised set of measures for evaluating collaboration. The National Health Performance Authority has recently released performance measures for primary health care that can be used and adapted for this purpose.[3]
- Roles and responsibilities – While health professionals reported a willingness to collaborate, there was a general lack of understanding of, and respect shown for, the roles and responsibilities of other health professionals (particularly among GPs). These issues were less apparent where health professionals are located in close proximity or where collaboration is necessary to deliver effective health care, such as in rural and remote areas.
- Communication – Timely and effective communication between all stakeholders is a necessary factor to enable collaboration (though not sufficient on its own). Communication among health professionals is generally perceived as ad hoc and slow unless there is "something in it" for them. A lack of time was cited as the main barrier to effective communication.
- Education and training – Education is currently delivered according to each profession with little interaction between professions at the undergraduate level.[4] Further support and training around collaborative practices, including interdisciplinary undergraduate training in subjects common to all health professionals, was reported as necessary. Interdisciplinary clinical placements were also identified as an opportunity to encourage the greater understanding of professional roles and capabilities across primary health care professionals.

The common foundation of all of these findings is the importance of the consumer. There was agreement among stakeholders and health professionals that collaboration is ultimately for the benefit of the consumer and that the consumer should be at the centre of care. There is clear evidence of the benefits to consumers and their families when health professionals and organisations work together to coordinate services; this makes a compelling case to coordinate care around the needs of people and populations (Ham and Walsh, 2013). Internationally, health systems that have successfully integrated health care services have done so by keeping the consumer at the heart of the system.

All of the themes identified above – formed from evidence collected across the project – provided the foundations of the proposed model described below.

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[1] The project was carried out across five phases of work, including stakeholder consultations, a literature review and mapping exercise, a national survey of primary health professionals, and a national Design Forum to gain shared vision and agreement between 61 primary health care stakeholders and to develop a recommended model of professional collaboration.

[2] 'Health professionals' in the context of this report refers to both 'health practitioners' and 'health service managers' working in a primary care setting.

[3] The most recent version of these measures is available from the NHPA website: http://www.nhpa.gov.au/internet/nhpa/publishing.nsf

[4] It is noted that some universities are already exploring these opportunities within their own campuses, but the practice is not widespread or consistent across Australia.

1.1 *A model of professional collaboration*

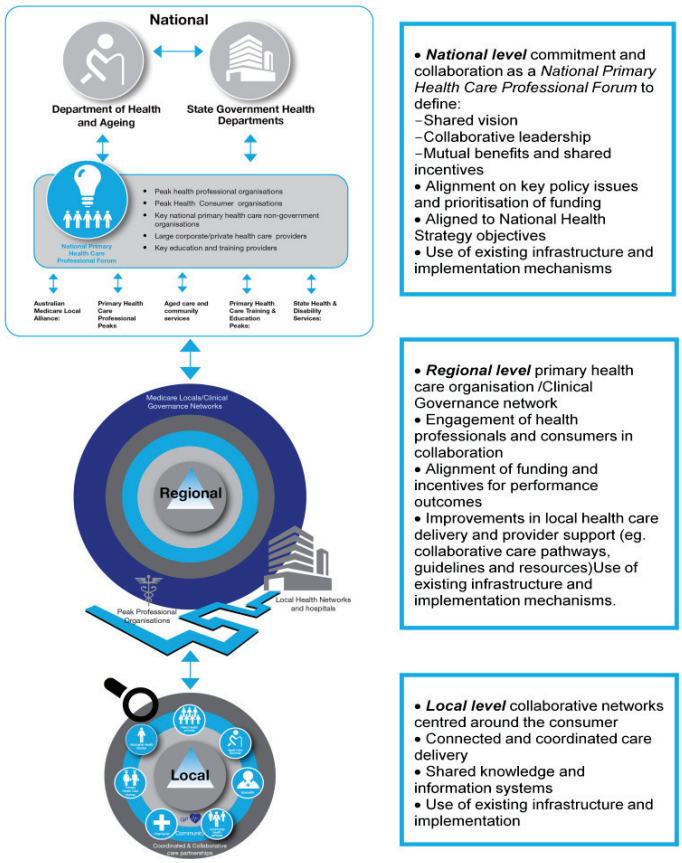
In the current context of health system reform, all professionals are being asked to take a systems-thinking approach to the delivery of care, i.e. to consider the Australian health care system as one system, with multiple sub-systems (e.g. state-based, acute care, primary care) that influence the overall outcome. Looking at the primary health care system in this way provides the opportunity to reassess what it means to be a primary health care professional within a primary health care team, and to understand where each set of health care skills is used best to benefit consumers of the health care system.

The model proposes:

A three-tier model comprising national, regional and local levels (see Figure 1). This is in line with international literature on integration occurring at the micro, meso and macro levels (Pim et al., 2013).

- The formation of a *National Primary Health Care Professional Forum* to provide overarching leadership and strategic vision for the role and function of each of the key players involved. In order to achieve collaborative care, identifying a common purpose between different professions and organisations, and shared arrangements for leadership and governance are key. The principles on which the Forum is based can then pass onto the regional level via Medicare Locals and then to the local practice levels of the model through a range of activities such as case conferencing.
- A structure that encourages change in behaviour and attitude, facilitated by a range of key agreed principles.
- Engagement of front-line health professionals through transparent and real 'bottom-up' and 'top-down' communication. As such, throughout the implementation of the model, experiences at local and regional level will help inform the national approach to collaboration. Medicare Locals will play a key role in linking communication and initiatives from the local and national levels.

Figure 1: Overview of the model of professional collaboration



Importantly, the model leverages and builds on existing infrastructures (e.g. Medicare Locals), partnerships (e.g. Lead Clinicians Group) and models (e.g. the Home Medicines Review program and multidisciplinary chronic disease programs) wherever possible and does not attempt to create further layers of complexity or bureaucracy. As such, the *National Primary Health Care Professional Forum* can build on the National Primary Healthcare Partnership (who already gather on a regular basis), but should also include peak bodies that currently do not participate in it, such as the Australian Medical Association and the Royal Australian College of General Practice. Participants will demonstrate leadership in establishing the best possible role model and environment for professional collaboration.

The key objective of the regional and local parts of the model is to have a central focus on the needs of the consumer as facilitated through a local collaborative care partnership. In this model, the consumer can enter a '*Primary Health Care Collaboration Partnership*'[5] through any primary health care professional, where every consultation with a primary health care professional is an opportunity for better health outcomes, and each consumer can be advised and/or referred on the basis of clinical need to the most appropriate source and location for care. There is a real potential to improve care at the local level in this way by involving all stakeholders necessary to deliver effective and quality care.

[5] '*Primary Health Care Collaboration Partnership' is a working definition/title* referring to a defined group of local primary health care providers that opt in to participate in collaborative care arrangements.

In this model, Medicare Locals are accountable for making progress on collaboration between primary health care providers at the regional and local levels, both within and between professions. They therefore have a vested interest in supporting local providers to form collaborative partnerships. In order to establish a functioning model at this level, regional stakeholders will need a collective understanding of the key barriers and enablers to collaborative relationships and care; the services and skills available (and any gaps) within the region; the roles and scope of practice of health care providers in the regions (building on the work of the *National Primary Health Care Professional Forum*); and existing opportunities for integrating services and locating them together.

1.2 Recommendations

Collaboration between health care professionals in Australia is challenging but the benefits of collaboration to the Australian health care system are clear: the better delivery of effective and quality health care to the Australian consumer. Collaboration requires the commitment of individuals and the peak body organisations that represent them. It needs to be driven from the ground up while at the same time, health care professionals and peak bodies come together to move forward a positive shared vision for primary health care.

The key recommendations for implementing the model of professional collaboration are to be carried out at the same time at both the local and national level:

1. The Pharmacy Guild of Australia should endorse and implement the model at the national governance level. This includes: (a) seeking endorsement of the model by primary health care peak bodies; (b) initiating discussions between key primary health care professional bodies about what areas to align to deliver more integrated and multidisciplinary care, and to identify existing agreement on policies; (c) the Department of Health and Ageing to endorse the proposed model (or a further version of this model as agreed by the relevant peak bodies) including the formation of the *National Primary Health Care Professional Forum.* The first activity of the forum will be to establish terms of reference and create and endorse a charter for professional collaboration; and (d) the *National Primary Health Care Professional Forum* to drive changes in training, education and clinical placements through universities – including how to work as an interdisciplinary team, and core subjects for all health professionals such as ethics, privacy and leadership.
2. The Department of Health and Ageing should commission an assessment of change readiness and develop a leadership programs across the primary health care sector. Change of this magnitude will require leadership and continuous commitment from all participants. It will also require effective change management in order to drive real and sustainable change, and this will require an understanding of stakeholders' willingness and readiness. While this project has demonstrated a range of stakeholder views and their readiness for change, a full assessment would provide the basis for a more detailed and strategic approach.
3. Health professionals and consumers should drive change from the bottom-up by leveraging the infrastructure and support of Medicare Locals. In order to drive change at a local and regional level, health professionals and consumers at a local level should: (a) proactively engage with their Medicare Locals to better understand their plans for integrating services in the local region - as professional collaboration will be a first key step on this path to integration; (b) volunteer to be on the Board or Advisory Committees of their Medicare Locals to help shape the direction of local services; as demonstrated by the Gold Coast Medicare Local, there are real opportunities for primary health care professionals to work collectively together to identify local health solutions and ways of working; (c) seek information from their Medicare Locals on local population health needs (e.g. chronic disease, mental health, after-hours services) identified as a priority and the strategy for addressing them; proposals for collaborative services will be better received and supported if they align with the identified needs of the population; (d) establish practice standards that are created and relevant at the local level, based on the nationally agreed charter/code of collaborative practice standards; each Medicare Local has the mandate to establish stronger clinical governance processes and collaboration should form a key part of practice standards to be upheld; and (e) identify any regional-level barriers to collaboration that can be addressed with clinician-led local solutions or low-cost investments. This may include open and facilitated meetings between GPs, specialists and pharmacists in the region to improve local access, diagnostic or referral issues.
4. Primary health care professionals should build better local relationships. Of all the enablers to collaboration identified in the *Professional Collaboration* project, strong relationships and communication were the most significant. Based on this, all primary health care professionals should: (a) identify opportunities to engage with health professionals in the local region; this may include face-to-face meetings with fellow health professionals and not just communicating via email or fax; and (b) reach out to other professions to discuss collaborative initiatives that address local health issues; this may include establishing multidisciplinary groups or committees on areas of common interest, such as paediatric or diabetes special interest groups.

2 Background

This section provides background to the Professional Collaboration project including the context in which it was undertaken, the role of primary health care in Australia and current reforms, the role of community pharmacy in primary health care and the need for professional collaboration and its challenges.

2.1 Project background

The aim of the *Professional Collaboration* project ('the project') was to identify a model of best practice for collaboration between community pharmacists and other health professionals in the primary health care system in Australia that will lead to positive benefits for consumers and the broader health care system. The project was undertaken by a Research Team led by PwC and included the Graduate School of Pharmacy at the University of Technology Sydney (UTS). The project recognised that any proposed model must be feasible within the setting of current and future policy and that it must be possible to implement and put into action the model's recommendations. The project must also be aligned with the overall strategic aims of relevant stakeholders and with wider health care reform. The project commenced in July 2011.

This project was overseen by an Advisory Panel with representatives from the Australian Government Department of Health and Ageing (DoHA), the Pharmacy Guild of Australia ('the Guild'), the Pharmaceutical Society of Australia (PSA), the Consumers Health Forum of Australia (CHF) and a research specialist. The role of the panel was to provide input into and oversight of the project's research and deliverables.

This project takes place in the context of primary health care reform aimed at improving access to and coordination of care, health promotion and disease prevention and builds upon existing evidence of the benefits of multidisciplinary care.

In order to achieve the aim of the project as outlined above, the project sought to map existing multidisciplinary care arrangements, collate evidence on professional collaboration models from existing literature and engage with primary health professionals to determine a preferred model for collaboration. The project recognised that any model proposed must be feasible within current and future policy settings and that the outcomes of the research must be actionable, implementable and aligned with the overall strategic aims of relevant stakeholders and wider health care reform.

The project included: consultations with key stakeholders and domestic and international pharmacy experts; a literature review of enablers and barriers of professional collaboration and mapping exercise of existing models; a survey of primary health professionals; and a Design Forum where stakeholders collaborated in the design of a practical, sustainable model.

In the context of this report, professional collaboration refers to the collaboration between community pharmacists and other health professionals in Australia's primary health care system.

2.2 Context to the project

2.2.1 Primary health care in Australia

The importance of a strong primary health care system in Australia and the current reforms that it is undergoing set the context for the *Professional Collaboration* project.

The primary health care system is the foundation of the broader health care system. As defined above, primary health care is understood as 'the care provided at the first level of contact with the health care system, the point at which health services are mobilised and coordinated to promote health, prevent illness, care for common illness, and manage health problems' (National Forum on Health Canada, 2004). Contemporary definitions of primary health care also recognise that health is in fact determined by complex interactions between health care, social and environmental context. Primary health care works at this interface of health care and the social determinants of health. It deals with the complex interaction of biological and social causation of illness and defines interventions on the social context of consumers and communities.

Historically, primary health care in Australia has been complex, fragmented and disconnected. This lack of cohesion has been due to differences in: the levels of government; their different roles, responsibilities and funding models; and the diversity of systems to deliver health care by the public, private and non-government sectors. The consequences of this have been negative:

Every year Australians have an average of 22 interactions with the health system, including four visits to a GP, 12 prescriptions and three visits to a specialist (Australian Government Department of Health and Ageing eHealth, nd). Most of these services occur in a disconnected manner and important information regarding patients is not communicated or fed back. Some of these services may even be duplicative in purpose (Commonwealth of Australia, 2011).

Internationally and in Australia, governments have realised that achieving healthy communities requires better integration of health care, social and environmental systems and they have set about strengthening their primary health care systems. In 2010, DoHA in partnership with State and Territory governments and other key stakeholders embarked on an ambitious health reform agenda to transform the primary health care sector.

2.2.2 Primary health care reform

Australia released its first National Primary Health Care Strategy, *Building a 21st Century Primary Health Care System,* in February 2010.The vision of the strategy (Australian Government Department of Health and Ageing, 2012) [6] was:

...improve access to a more comprehensive and multidisciplinary range of primary health care and specialist services in the community so that consumers can get access to expanded range of services with better coordinated referrals and network services through more convenient times.

The goal of the health reforms and this strategy is to improve the quality, safety, performance and accountability of the health care system through:

- The health system being more financially sustainable with an increasing share of public hospital costs being met by the Australian Government into the future
- More locally responsive planning and management of health services
- Better publicly available information on the performance of health services
- Stronger collaboration in developing national policy directions and strategic priorities within and across government
- More focus on prevention
- Better management of chronic diseases
- Improving access and reducing inequity.

To achieve these goals, the government has started to establish the structures, governance models and capabilities required to achieve better coordinated and more effective delivery of health care. Initial reforms included:

- Establishing 61 Medicare Locals nationally
- Establishing 64 GP Super Clinics nationally
- Trialling new approaches for the flexible delivery of treatment and management of diabetes through general practice
- Increasing access to after-hours services through the availability of the after-hours GP helpline and by tasking Medicare Locals with a range of after-hours primary health care responsibilities
- Funding approximately 425 primary health care infrastructure upgrades to general practices, primary health care and community health services and Aboriginal Medical Services to improve access to integrated GP and primary health care

Key initiatives have specific implications for professional collaboration and will help drive improvements in the way in which health professionals collaborate and similarly, the way in which consumers can access coordinated care.

2.2.3 Key health reform initiatives

More specifically, the key health reform initiatives which have implications for professional collaboration are: the establishment of a network of Medicare Locals, Local Hospital Networks and GP Super Clinics; the introduction of a national eHealth records system; investment in primary health care infrastructure; and efforts to boost the primary health care workforce.

[6] The National Primary Health Care Strategic Framework Consultation Draft (2012) was circulated for consultation but is not yet publicly available at the point of publication.

The establishment of a nation-wide network of Medicare Locals, GP Super Clinics and Local Hospital Networks

Medicare Locals are the flagship for the national health reform in relation to primary health care. Like similar organisations around the world, Medicare Locals have an ambitious mandate to use population health planning to integrate innovative local service design and provision with the social, environmental, and economic determinants of health. Medicare Locals aim to coordinate and integrate primary health care delivery in a particular geographical area, focusing on local health needs and service gaps, while linking GPs, nurses and other primary health professionals and Aboriginal and Torres Strait Islander health organisations with acute and aged care services. Currently, all 61 Medicare Locals have commenced establishment and operational activities. Medicare Locals are seen as a key way to improve the integration of care, and to provide consumers and communities with health care services (Australian Medicare Local Alliance, 2012).

GP Super Clinics are physical infrastructures where community members can access a range of health professionals such as GPs, nurses, and pharmacists and receive a varied range of health care services (Australian Government Department of Health and Ageing, 2011). Funding has been invested to establish 64 GP Super Clinics across Australia. They represent a significant investment in primary health care infrastructure. In an evaluation of the set-up of GP Super Clinics in 2007–2008, it was found that consumers have increased access to primary health care in a multidisciplinary setting and report positive experiences about access to and the quality of their care. Furthermore, retention and recruitment of GPs was supported (Consan Consulting, 2012).

Local Hospital Networks (LHNs)are small groups of acute care services (including hospitals) that have been identified to work together to deliver acute and sub-acute services within specific regions. Together, they are expected to collaborate with Medicare Locals to deliver better consumer care within budget constraints. The boundaries for 137 Local Hospital Networks have been agreed to date across all states and territories. There are 124 geographically based networks and 13 state-wide networks which will deliver specialised hospital services across some jurisdictions (Australian Government Department of Health and Ageing, nd).

A national eHealth record system

An investment of $466.7 million in the national eHealth record system is being made over a two-year period and will allow improved health care delivery by improving access to information and cutting waste and duplication. It will be secure system of personally controlled electronic health records that will provide: summaries of consumers' health information including medications; immunisations and medical test results; secure access for consumers and health care providers to eHealth records through the internet regardless of their physical location; and rigorous governance and oversight to maintain privacy (Australian Government Department of Health and Ageing, 2010).

It is anticipated that a national eHealth record system will allow consumers to be empowered with easy-to-access information about their medical history and to make informed choices about their health care with improved consumer safety. They will be able to present for treatment anywhere in the country and give permission for health professionals to access their relevant history at the touch of a button.

Investment in primary health care infrastructure

Greater investment has been made in primary health care infrastructure through the Primary Care Infrastructure Grants and with investment in the after-hours GP helpline. Primary Care Infrastructure Grants are provided to general practices, primary health care, community health services and Aboriginal Medical Services (AMS) to improve consumer access to integrated GP and primary health care. In 2010–2011, the Australian Government invested $117 million in these grants to upgrade around 425 services.

DoHA will also increase access to after-hours services through the availability of the after-hours GP helpline, delivered through the National Health Call Centre Network, and by tasking Medicare Locals with a range of after-hours primary health care responsibilities (Australian Government Department of Health and Ageing, 2010).

Boosting the primary health care health workforce

In addition to structural changes in primary health care, the roles of some health professionals are also changing. One of the five key building blocks of the national strategy is a skilled workforce, a workforce that is flexible and well trained, has clear roles and responsibilities built around core competencies and works collaboratively. Due to the increase in the incidence of chronic diseases in Australia, and workforce misalignments more widely, DoHA has increased the emphasis on enabling multidisciplinary care within a primary health care setting. Mechanisms to do this include increased prescribing rights for nurses, larger roles for practice nurses and increased roles of pharmacists in medication management services.

2.2.4 Consumer-centred health care

The health reform initiatives described above are aligned to a major health care reform that is conceptual in nature: the design of a health care system that places the consumer at the centre of it. A 'consumer-centred' model draws on the values of the World Health Organization's (2006) definition of 'person-centred health care'. These values include empowerment, participation, access, and the central role of family and community. This means that people have the right and duty to participate in and make decisions about their health care, not only regarding treatment and management, but also in broader issues of health care planning and implementation.

DoHA (2009) has articulated this as:

... a primary health care system which is designed around supporting the individual, their family and carers to be in control and actively supported in their care. It is also about a system which is easy for them to access the care they need and which helps them to manage their health care needs and stay as healthy as possible.

- This focus on consumer-centred health care has happened all around the world. It is represented by a literal shift from references in health care literature and discussions from 'patients', who may be passive recipients of health care to references to 'consumers' who make decisions about and actively participate in their health care. This empowerment of consumers is supported by many current Australian policies and statements such as the Community Pharmacy Service Charter, as well as through the growing influence of advocacy groups such as the CHF.
- Increasing efforts to improve consumers' level of health literacy also supports this effort to empower consumers. Health literacy is a risk factor for poor health (Kanj and Mitic, 2009) and only 41% of Australians have adequate levels of health literacy (ABS, 2006). So it can be assumed that a shift towards a consumer-centred model of care will need to focus on improving health literacy as a means to empower consumers and allow them to better access, understand and participate in their health care.

The changes to primary health care governance and infrastructure, with the introduction of Medicare Locals and GP Super Clinics, supports this movement towards consumer-centred care by encouraging better coordination between service providers and easier access to providers by consumers. Meanwhile, the development of the national eHealth record system will help empower consumers to take responsibility for and make informed choices about their health care. The consumer-centred care model focuses on the consumer's choice as to where, how and when they initially seek primary health care and can be informed by:

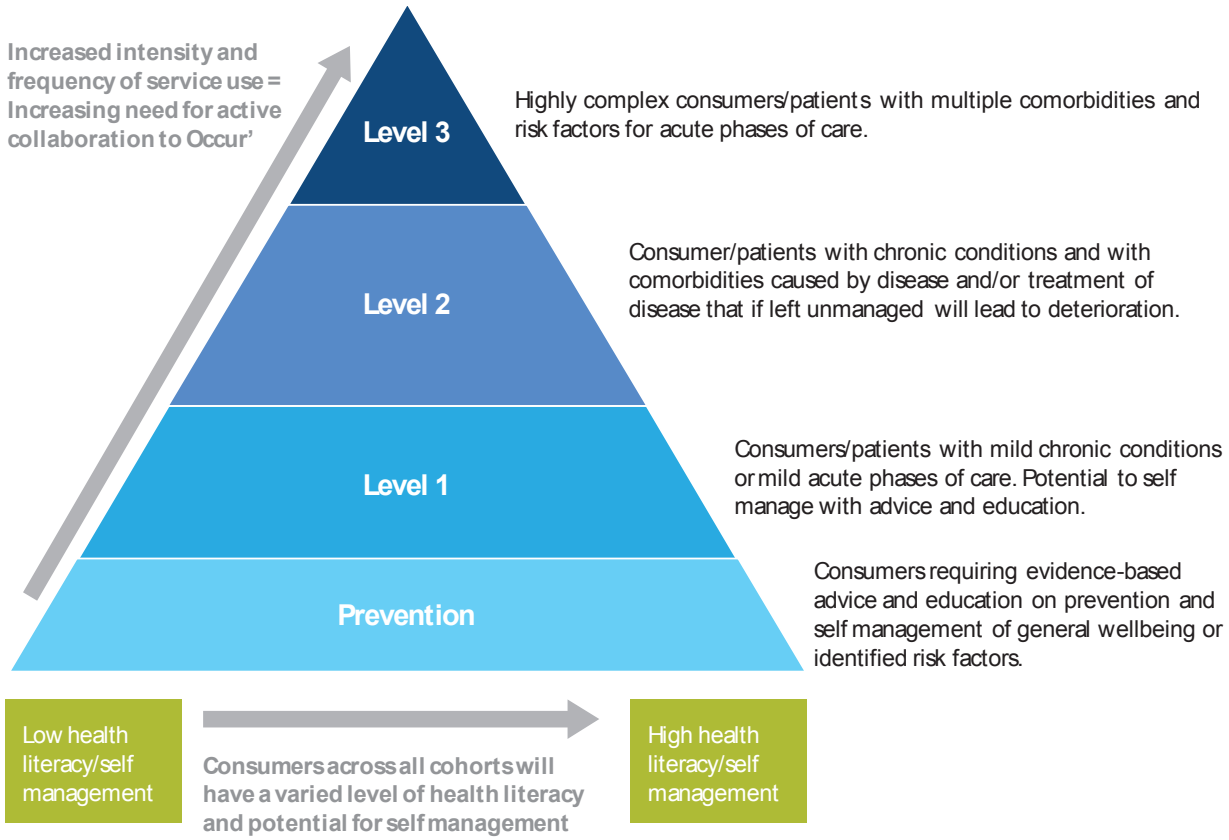
- Accessibility of care and advice – This can include waiting times, opening hours, the need for or ability to make appointments, location, cost, and cultural appropriateness and safety.
- Health need – This can range from concerns regarding potential risk factors through to highly complex chronic or acute needs.
- Health literacy – This can depend on variables such as age, gender, socioeconomic status, prior training, previous treatment provided and specific experiences of disease and treatment.

In this context, some consumer/patient cohorts may have a greater potential benefit from improved professional collaboration than others. A commonly used framework for segmenting chronic disease population cohorts has been the Kaiser Permanente pyramid approach. This defines a proactive approach to managing care for consumers with long-term conditions. Its distinguishing feature is that it aims to remove distinctions between primary and secondary care for people at all stages (NHS, 2006).

For the purposes of this project, a potential model for segmenting the needs of primary health care consumer has been proposed in Figure 2. Consumers who have more intense and frequent use of health services may benefit the most from improved collaboration. That is, those in Levels 2 and 3 have the greatest potential to benefit from streamlined, connected and collaborative care and also present the most cost efficiencies to be gained. However, it is also noted that all consumers potentially benefit from improved collaboration when they are in contact with health services.

A second continuum is also depicted at the bottom of this diagram to represent the presence of different types of consumers within each level. That is, a consumer's health literacy and the potential for self management impacts the frequency and duration of support required.

Figure 2: Primary health care consumer needs – potential cohort segmentations (adapted from Kaiser Permanente Pyramid



A focus on the consumer and ensuring their involvement in health care is an important principle in collaboration between health professionals (Tieman et al., 2007); encouraging consumers to actively participate in their coordinated care can form part of the team's dynamic of collaboration (D'Amour and Oandasan, 2005).

Internationally, health systems that have successfully integrated care services have done so with consumer-centred care. The Canterbury District Health Board in New Zealand went as far as making all decisions on the basis of 'not wasting consumers' time' (Gullery, 2013).

2.2.5 *Pharmacy in Australia*

Within the primary health care system in Australia, and its reform context, community pharmacy plays an important role and is well positioned to play an even broader one.[7] There are over 15,000 community pharmacists in Australia, who work in approximately 5,000 community pharmacies (The Pharmacy Guild of Australia, 2008). It has been estimated that each pharmacy serves a community of 4,000 people and that, on average, a person will visit a pharmacy around 14 times a year (The Pharmaceutical Society of Australia, 2010). A recent survey of Australians ranked pharmacists as the second most honest and ethical profession after nurses (Roy Morgan, 2012).

Community pharmacy services are highly accessible to consumers as in the vast majority of cases; these services are offered to consumers free of charge and without the need to make an appointment. The *Australian Health Survey* (Menzies Centre for Health Policy, 2012) reported that pharmacists had the highest ratings of all health services of level of satisfaction (89%). Pharmacies were one of the most commonly used health service (94% of survey respondents had used one). By way of comparison, only 52% had been to a public hospital and 41% had used an allied health provider.

[7] While there are a variety of different settings in which pharmacists work (e.g. hospitals and clinics, community health centres and community pharmacies), this project focuses on community pharmacy.

The current context of increasing complexity in illness and treatments also points to why community pharmacists must be included in a interdisciplinary care approach: they are medicine experts trained in providing professional advice and counselling on medications to consumers and health professionals including their use and effects With pharmacy practice firmly underpinned by Australia's policy on the Quality Use of Medicines (QUM), the role of pharmacists relates not only to medicines use and management, but also to providing advice on non-drug management where appropriate, and providing support and information to work across the whole spectrum of health from prevention to management of ill health (Australian Government Department of Health and Ageing, 2002).

The practice of community pharmacy in Australia has progressively moved from the traditional role of dispensing medications to encompass the broader provisions of health care services i.e. cognitive professional services such as medication reviews. Numerous studies demonstrate that community pharmacist interventions and support results in improved consumer health outcomes, improved education and adherence, reduced hospitalisation and overall reduced health care costs (Baran et al, 1999; Roughhead, 2009).

In Australia, the Guild is the peak body organisation representing community pharmacy. It represents the interests of its members and supports community pharmacy in its role delivering quality health outcomes for all Australians (The Pharmacy Guild of Australia, nd). Meanwhile, the PSA is the national peak body organisation representing the pharmacy professional; including Australia's 25,000 pharmacists working in all sectors and across all locations. The PSA's focus is on the provision of continuing professional development and practice support for pharmacists (The Pharmaceutical Society of Australia).

2.3 Professional collaboration

Having described the primary health care context in Australia and the broader need for consumer-centred health care, an overview of professional collaboration is described here, including a definition of professional collaboration, a case for change and a summary of professional collaboration in Australia.

More specifically, in the context of this report, professional collaboration refers to the collaboration between community pharmacists and other health professionals in Australia's primary health care system. Professional collaboration works to address many of the challenges faced by primary health care in Australia, in particular, the complex and fragmented method of care delivery – as it allows health professionals to operate in a more coordinated and effective way. Care for consumers that is better coordinated between health disciplines can help address the challenges of an ageing population, the increasing prevalence of chronic diseases and the growing demands these place on health services. It can also prevent duplication of and disconnection between services.

2.3.1 Definition

In a study on the common themes of collaborative practices worldwide, the World Health Organization (2010) defined collaborative practice in health as:

occurring when multiple health workers provide comprehensive services by working together synergistically along with consumers, their families, carers and communities to deliver the highest quality care across settings.

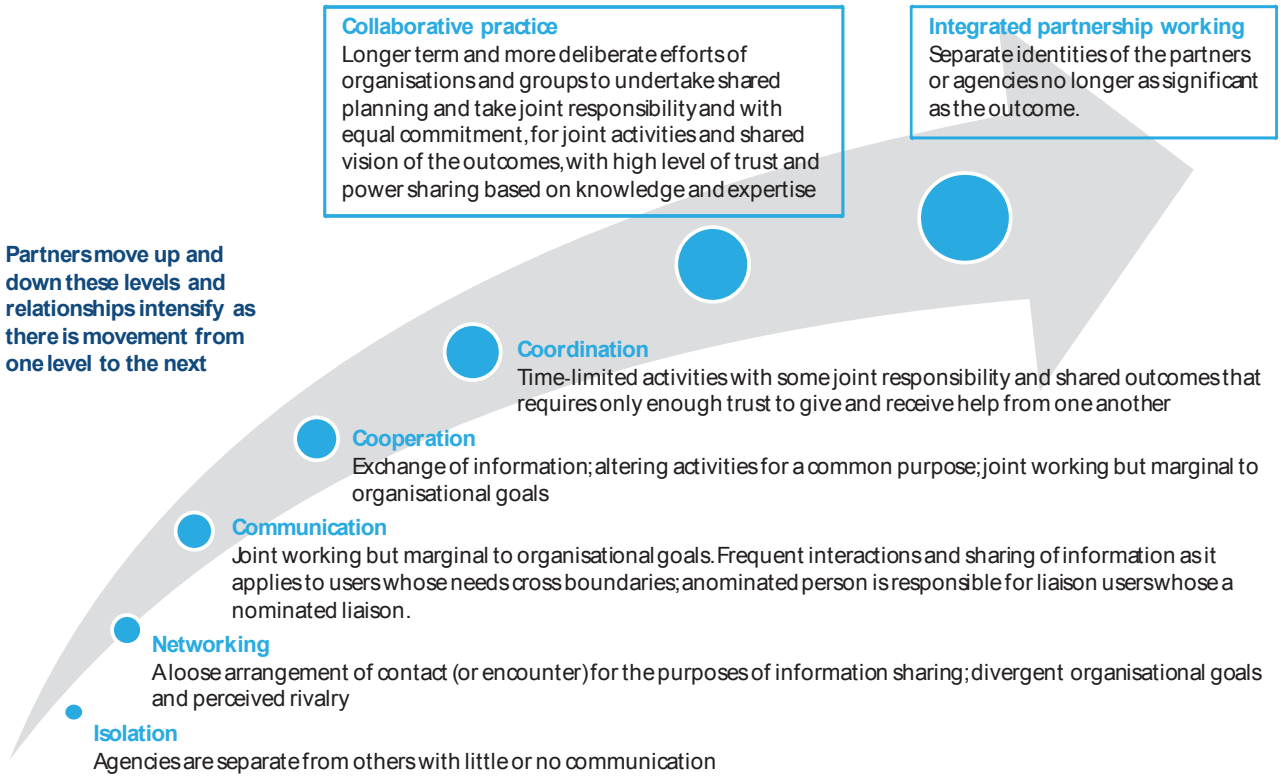
The term 'collaboration' is often used inappropriately in place of communication or networking, however, the characteristics of collaboration involves a more intense relationship between parties than these other types of partnership (Keleher, 2012). Figure 3 illustrates the differences between collaborative practice in relation to other forms of partnerships.

Collaboration involves a degree of voluntary agreement between health professionals (Axelsson and Axelsson, 2006) and can be established through a common goal or decision process (Wells, 1998). Collaborations and partnerships are quite well developed in theory but less so in practice. Both are forms of organisational affiliation but are not interchangeable concepts (Keleher, 2012). A partnership refers to identity or 'who we are' e.g. a project partnership that is usually time-limited, while collaboration is about 'what we do together'.

Collaborative practice is characterised by long term and deliberate efforts of individuals and groups to undertake a shared vision with shared planning and joint responsibility for the outcomes. There is a high level of trust and power sharing based on relevant participants' area of knowledge and expertise.

A true collaboration achieves collaborative advantage which refers to the benefits achieved when an individual or organisation accomplishes more than it would have independently, by developing effective working relationships with other individuals or organisations.

Figure 3: Stages of partnership (Keleher, 2012)



Previous social and organisational research has established a high level of intergroup bias as a typical occurrence between health professionals (Anconda, 1990). These attitudinal biases are evidenced to be heavily influenced by group leadership behaviours and often develop without any interaction between the professions (Richter, 2006). More recently, with increasing pressure on health professionals to work together to deliver collaborative and ideally integrated consumer care, there has been recognition by researchers that there is a lack of common understanding regarding what this is across inter-organisational and inter-professional boundaries (Evans and Baker, 2012). This research also identified several psychological factors that may influence inter-organisational and inter-professional relations. That is, underlying cognitions and the convergence and divergence of stakeholders' knowledge and beliefs in relation to collaboration or integration were found to influence interactions between health professionals (or lack thereof) across the continuum of care (Evans and Ross Baker, 2012).

Inter-group attitudinal bias includes the beliefs within a professional group regarding specific groups of their colleagues, often based on the setting and type of care delivered or the perceived knowledge gap (e.g. general practice medicine as hospital-based/private specialist services, hospital-based pharmacy and Community-based pharmacy). The *Professional Collaboration* project explored the issue of inter-group attitudinal bias between primary health care professions and intra-professional attitudinal bias within the relevant primary health care professions.

2.3.2 *The need for collaboration*

A key recommendation in the National Health and Hospitals Reform Commission (2009) final report, *A Healthier Future For All Australians* is to 'improve access to a more comprehensive and multidisciplinary range of primary health care and specialist services in the community so that consumers can get access to expanded range of services with better coordinated referrals and network services through more convenient times'.

More broadly, the ability for primary health care providers to work collaboratively to provide connected care is integral to primary health care in a number of different health care settings. Professional collaboration can help address the challenges

faced by primary health care in Australia, in particular, the complex and fragmented method of care delivery- as it allows health professionals to operate in a more coordinated and effective way. Better interdisciplinary and coordinated care for consumers can address the challenges of an ageing population, increasing prevalence of chronic diseases and a growing demand on health services (Australian Government Department of Health and Ageing, 2008). It would prevent duplication of and disconnection between services. Consumers or carers, who may not receive effective and comprehensive communication, would also not be forced to act as a conduit between primary health care providers (Commonwealth of Australia, 2011).

The Australian Medical Association (AMA) in a document outlining guidelines to collaborative arrangements between medical practitioners and nurse practitioners have recognised the importance of professional collaboration going forward and that 'working with other health professionals is an everyday feature of clinical practice for a modern medical practitioner'. It also acknowledges the importance of doing so as 'effective teamwork can improve patient outcomes, create new opportunities for learning and build a shared understanding of the skills that each person brings'. Finally, it comments on collaboration and the alignment to reform as 'the Government is very committed to this… and there is a real need for the medical profession to make collaborative arrangements with nurse practitioners and midwives work in the interest of our patients' (Australian Medical Association, 2010).

The Australian Nursing Federation (ANF) in a submission regarding midwife professional indemnity stipulates that 'nurse practitioners and midwives are educated to function… collaboratively within a regulated framework. Their roles… may include, but is not limited to the directed referrals of patients to other health care professions… their role provide innovative and flexible health care delivery that complements other health care providers' (Australian Nursing Federation, 2009).

In line with this thinking by the professional peak bodies, both the Guild (The Pharmacy Guild of Australia, 2010) and the PSA (The Pharmaceutical Society of Australia, 2010) have released position papers outlining the broader role that community pharmacy should play in primary health care.

Within the contexts described previously, the need for community pharmacists to play a key role in primary health care is clear: both in collaboration with other health professionals and in defining and recognising their roles in the wider health care system (The Pharmacy Guild of Australia, 2010). In current research (National Prescribing Service, 2009), high rates of errors were reported in documentation during the transfer of care with 52–88% of transfer documents containing an error. International research supports these findings with approximately 70% of consumer-related adverse events caused by a lack of basic collaboration and communication between health care providers (Fewster-Theuente and Velsor-Friedrich, 2008).

Safety is only one area that can be improved through collaboration between pharmacists and primary health professionals. Recent research from the National Prescribing Service (NPS) found that 1 in 5 Australians have experienced an adverse effect from their medicine in the past 12 months and that 190,000 yearly hospital admissions are caused by an adverse drug event (ADE) or bad reactions to medication, resulting in extremely serious and sometimes fatal outcomes (National Prescribing Service, 2009). These incidents and admissions create a significant costly and avoidable pressure on the hospital system; the interaction between a community pharmacist, general practitioner and consumer is integral to reducing these occurrences (Geurts et al, 2012).

2.3.3 *Professional collaboration in Australia*

Models of collaborative care between multiple health professionals require a significant investment of time and effort by numerous stakeholders to identify and design appropriate solutions. It may take a long time before the benefits are realised. In this way, the collaborative care path is a significant 'leap of faith.' However, considering current primary health care reform, the strong evidence base of the benefits of multidisciplinary care and the need to address current workforce inefficiency, improved collaborative practices between health professionals is hugely important. Community pharmacists are well positioned to be involved in current reforms and improvements to Australia's primary health care.

The Guild (The Pharmacy Guild of Australia, 2010) and the PSA (The Pharmaceutical Society of Australia, 2010) have released position papers outlining the broader role that community pharmacy plays in primary health care. This includes:

- Assisting consumers with chronic disease to deal with their medication-related issues
- Assisting consumers in medication compliance and adherence
- Assisting other health professionals to make appropriate clinical decisions based on complete medication profile

- Assisting consumers with lifestyle and preventative health issues
- Being a focal point for health screening programs
- Being the referral point for Government awareness campaigns.

These agencies agree that community pharmacy is well placed to deliver positive health outcomes. The five-year 5th Community Pharmacy Agreement (5CPA) between the Australian Government and the Pharmacy Guild of Australia commenced on 1 July 2010. It recognises the key role played by community pharmacy in primary health care through the delivery of Pharmaceutical Benefits Scheme (PBS) medicines and related services (5th Community Pharmacy Agreement).

As part of the 5CPA, the Pharmacy Practice Incentive (PPI) program recognises the positive benefits from pharmacists collaborating with other health professionals, and offers annual incentive payments based on documentation of specific cases of professional collaboration, for example, in the areas of: home medicines review, dose administration aids, disease state management, medication adherence, smoking cessation, supplying pharmacy medicines and clinical interventions (The Pharmacy Guild of Australia, 2010).

3 Overview of the Professional Collaboration project

This section provides an overview of the Professional Collaboration project including its objectives, the methodology and timing and project governance. It also provides a roadmap to this report.

3.1 Objectives of the Professional Collaboration project

The purpose of the *Professional Collaboration* project was to identify a best practice model for the integration[8] of community pharmacists in the primary health care setting. The specific objectives of this project were to:

1 Undertake a mapping exercise of existing Australian and international examples of national and local-level collaborative arrangements in primary health care and identify enablers, barriers and elements of a preferred future model through consultations with relevant stakeholders

2 Undertake a comprehensive literature review of Australian, international, peer-reviewed and grey literature on professional collaboration examining in particular, existing definitions and frameworks, barriers and enablers to effective professional collaboration and considerations to change

3 Undertake a survey of a statistically significant survey sample of primary health professionals to assess views and experiences of professional collaboration including frequency of collaboration, preferred mode of communication, perceived benefits, enablers and barriers of collaboration and attitudes and behaviours towards collaboration.

4 Undertake a Design Forum with relevant stakeholders to create a better understanding of the current context, build consensus and alignment in the aim of a future model and design a practical and sustainable future model of professional collaboration

5 Using the findings and outputs of the project, further refine, develop and propose a future model of professional collaboration for primary health professionals in Australia and outline a roadmap for implementation to enable change

As this is an action-based research project the objectives have evolved with the progress of the project. This shift in focus has been guided and informed by the Professional Collaboration Project Advisory Panel.

[8] The term 'professional integration' was replaced with the term 'professional collaboration' during the first phase of the project after agreement by the Project Advisory Panel and the PwC project team and, henceforth, will be referred to as 'professional collaboration' in the following sections of the report..

3.2 Project methodology

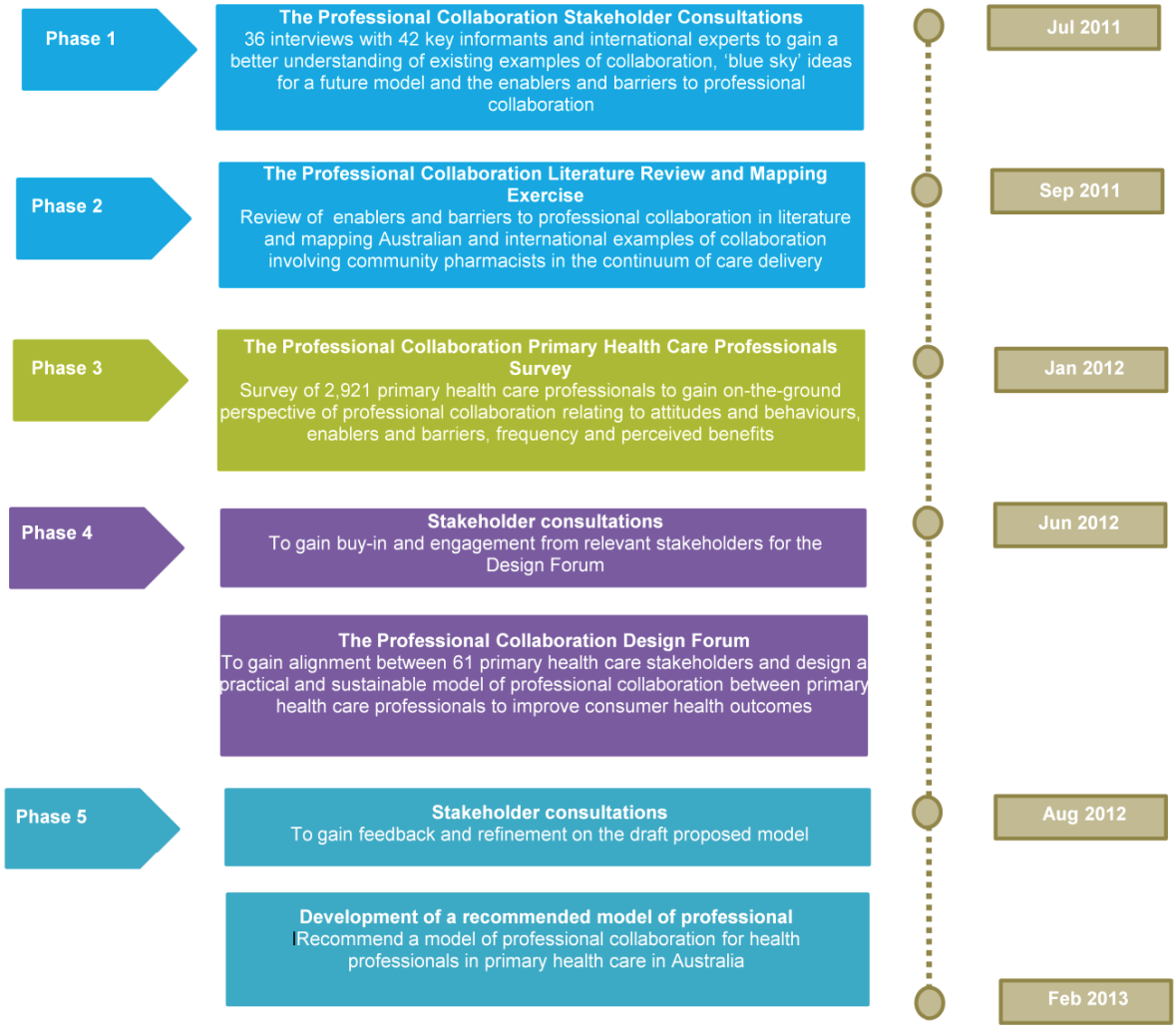
PwC has executed a technically robust research approach to the *Professional Collaboration* project in line with approaches for previous Community Pharmacy Agreement Research and Development projects. In addition, strong stakeholder engagement and buy-in for the project have been employed through regular consultation with key stakeholders from the primary health care sector. Findings from each phase of the project informed the key research questions of each subsequent phase and findings were continuously validated with key stakeholders and subject matter experts. This allowed development of a proposed model of professional collaboration that would be practical and sustainable given the current context of primary health care in Australia.

The *Professional Collaboration* project was designed with five phases of work:

- **Phase 1: The Professional Collaboration Stakeholder Consultations.** This involved 36 interviews with 42 key informants and international experts to gain a better understanding of existing examples of collaboration, 'blue sky' ideas for a future model and the enablers and barriers to professional collaboration (see Section 4 for further detail on the approach and key findings).
- **Phase 2: The Professional Collaboration Literature Review and Mapping Exercise.** This involved a review of enablers and barriers to professional collaboration in literature and mapping Australian and international examples of collaboration involving community pharmacists (see Section 5 for further detail on the approach and key findings).
- **Phase 3: The Professional Collaboration Primary Health Care Professionals Survey.** This involved a survey of 2,921 primary health professionals: pharmacists; GPs; nurses; and Allied Health professionals to gain an on-the-ground perspective of professional collaboration relating to attitudes and behaviours, enablers and barriers, frequency and perceived benefits (see Section 6 for further detail on the approach and key findings).
- **Phase 4: The Professional Collaboration Design Forum.** A Design Forum was held to gain alignment between 61 primary health care stakeholders and to design a practical and sustainable model of professional collaboration between primary health professionals that will improve health outcomes for consumers (see Section for further detail on the approach and key findings).
- **Phase 5: Development of a recommended model of professional collaboration.** As a result of the previous four phases of work, a model for professional collaboration was formulated – which then was consulted on with a number of primary health care stakeholders to validate the model (see Section 8 for further detail on the approach and key findings).

Figure 4 provides an overview of the timing of the phases and activities of the project.

Figure 4: The *Professional Collaboration* project timeline



3.3 Project governance

As part of the rigorous project governance approach to the *Professional Collaboration* project, the project was overseen by the Advisory Panel which included representatives from DoHA, the Guild, PSA, CHF and a research specialist. Their role was to provide expert input into and oversight to the research and project deliverables. The Research Team met with the Advisory Panel on four occasions.

At the commencement of the project, the project methodology underwent and was approved through a peer review by a GP representative to assess the appropriateness of the proposed study design, methodology and data collection and analysis tools. A second peer review of the *Professional Collaboration Draft Final Report* was undertaken to assess the project objectives against the methodology, interpretation of results and the conclusions and recommendations.

The Research Team, led by PwC, worked collaboratively with its project partner, the Graduate School of Pharmacy at UTS, as well as the Guild's project management team on a regular basis throughout the project. This continuous engagement was pivotal to providing input and feedback on key project activities and project deliverables.

3.4 Roadmap to the report

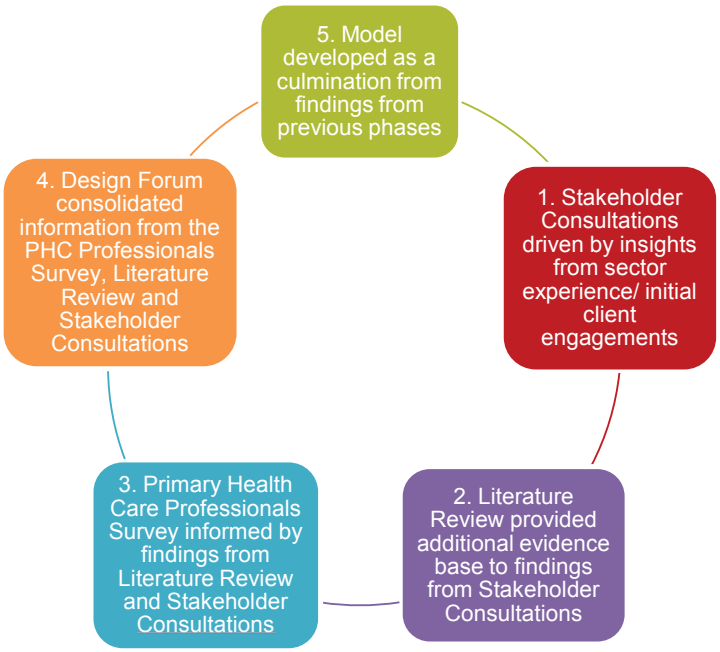
The purpose of this final report is to outline the findings of the *Professional Collaboration* project, including findings from the stakeholder consultation, literature review and survey. It also includes the outputs from the Design Forum, a model for future professional collaboration, recommendations and next steps.

The report is structured as follows:

- Section 1: Background
- Section 2: Overview of the *Professional Collaboration* project
- Section 3: Stakeholder consultations
- Section 4: The literature review and mapping exercise
- Section 5: Primary Health Care Professionals Survey
- Section 6: Professional Collaboration Design Forum
- Section 7: Key findings and implications for the model
- Section 8: Model of professional collaboration
- Section 9: Conclusion and next steps

The data collected from each of the phases of the project helped to inform and drive the approach of the following phases, as well as contributed to a cumulative evidence base on professional collaboration which was used as the basis of the development and recommendations regarding the model, as illustrated in Figure 5.

Figure 5: Data collection cycle



This final report summarises the key findings from the stakeholder consultations and literature review. For the complete findings, case studies and references please refer to the *Professional Collaboration Summary of Stakeholder Consultations* (5CPA, 2012), and *the Professional Collaboration Literature Review and Mapping Report* (5CPA, 2012), available on the 5th Community Pharmacy Agreement website.[9]

9 http://www.5cpa.com.au/iwovresources/documents/5CPA/Initiatives/Research_and_Development/Fifth_Agreement

4 Stakeholder consultation

This section provides an overview of the stakeholder consultation including its purpose, approach, key findings (including enablers and barriers to professional collaboration and elements for a preferred future model), and their implications for a model of professional collaboration.

4.1 Purpose

Consultations were undertaken nationally across a range of key stakeholder groups including pharmacy, general practice, allied health, nursing, other primary health care providers, government, Medicare Locals, consumer representatives, and international experts on the subject of pharmacy. The purpose of the stakeholder consultations was to gain an in-depth understanding of the views of organisations and individuals about professional collaboration in primary health care, in both Australia and internationally.

In particular, the stakeholder consultations focused on:

- Existing examples of multidisciplinary care
- Barriers of and enablers to professional collaboration
- Potential elements of a preferred model
- Preferred models of collaboration for community pharmacy.

4.2 Approach

The stakeholder consultation approach was based on a proven and tested methodology that is designed to be flexible, transparent and thorough while capturing the richness of participant's responses. The key areas of focus for the consultations were:

- **What do existing models of professional collaboration in health care look like?** This includes details of: what professions are involved; location; mechanisms of communication; governance, policies, structures and processes; incentives and funding; measures of effectiveness and indicators of success.
- **What are the barriers to professional collaboration?** This includes key barriers to professional collaboration in general and specific barriers for collaboration with different health professionals i.e. GPs, pharmacists, nurses and Allied Health professionals.
- **What are the enablers to professional collaboration?** This includes key enablers to professional collaboration in general and specific barriers for collaboration with different health professionals i.e. GPs, pharmacists, nurses and Allied Health professionals.
- **What is a future model of professional collaboration for community pharmacists?** This includes: the preferred model and mechanisms for a future model; key benefits of this model; communication mechanisms required; resources required; incentives; and governance, policies and structures required.

Semi-structured interviews were undertaken via face-to-face meetings and teleconferences with stakeholders and ran for up to an hour. A discussion guide was provided to participants prior to the consultation which outlined the context of the project and the questions which would be covered (please see Appendix B. Each consultation was led by a senior member of the Research Team, while a second team member attended to take notes.

Stakeholders were identified by the Research Team and agreed with the Advisory Panel. A total of 36 consultations were undertaken with 42 individuals, representing 34 organisations. Five organisations declined to participate. A full list of the organisations that participated in consultations is included in the Appendix A of this report.

It should be noted that the consultations took place between November 2011 and January 2012. During this time, the Guild and the pharmacy profession more broadly, were facing a number of highly publicised challenges. While these issues were raised in some of the consultations, they did not significantly affect the outcomes of the consultation.

Upon completion of the consultation process, a high-level thematic analysis was undertaken on the qualitative consultation notes. Any form of identifier was removed to ensure anonymity.

The summation of the data was then reviewed to ensure consistency within primary themes. Primary themes were then confirmed with the second person who participated in the consultations to ensure consistency and the relevance of language used. No frequencies were assigned to the themes. It was deemed more important to focus on the richness of the data, rather than the frequency of the responses provided.

The Professional Collaboration Summary of Stakeholder Consultations (5CPA, 2012) is available on the 5CPA website.[10]

4.3 Discussion of findings

The stakeholder consultations provided a broad range of views on the key enablers and barriers to professional collaboration, and also identified examples where professional collaboration is working well in the national and international primary health care setting and what the preferred elements of a future model would be. While pockets of excellence were identified, there appeared to be no systemic process by while collaborative practices were applied more widely.

4.3.1 Examples of collaboration

The consultation process identified examples of successful collaboration which were occurring in the health care sector through informal networks or driven by individual professionals. There were a number of examples where professional collaboration involving community pharmacists is working well in primary health care – both in Australia and internationally. Examples of successful collaborative practices regularly identified by stakeholders included health professionals working together in the following contexts:

- Rural and remote areas
- Multidisciplinary hospital teams
- Residential aged care
- Co-location of GPs and practice nurses
- Medication reviews in a number of countries including Australia
- Multidisciplinary care planning – particularly for chronic illness
- Collaboration based on local health needs in the UK
- More specific programs that were identified to involve collaboration in Australia and internationally included:
- Quality Use of Medicines Maximised (QUMAX) for Aboriginal and Torres Strait Islander peoples
- Home Medication Review (HMR)/Residential Medication Management Review (RMMR)
- The Diabetes Coordinated Care trial in Queensland and South Australia
- GP Management Plans and Team Care Arrangements for consumers with chronic disease
- The Hospital Admission Risk Program in Victoria
- Primary Care Partnerships in Victoria
- The National Rural Health Alliance
- Integrating Family Medicine and Pharmacy to Advance Primary Care Therapeutics program in Canada
- Primary Health Care Clinics/Medical Centres with a pharmacist as identified in a number of countries.

[10] http://www.5cpa.com.au/sites/5CPA/Initiatives/Research_and_Development/Fifth_Agreement/Fifth_Agreement/RFT2010_11-05%20Professional%20Integration.page

4.3.2 Enablers

The stakeholder consultations identified enablers to professional collaboration within primary health care – both from a general perspective but also included specific examples from community pharmacy. Barriers, enablers and elements of a preferred model have been grouped under the following themes:

- Policy, governance and funding
- Infrastructure, systems and support
- Communication and shared activities
- Professional relationships
- Focus on the consumer

Each of these enablers is described in further detail below.

Policy, governance and funding

- **Funding mechanisms:** Shifting the current funding model towards one where professional collaboration is appropriate incentivised or rewarded, 'ring-fenced' and constant. Stakeholders reported that the PPI was a good example of payment attached to the demonstration of an output, such as communication between health care providers.
- **Peak body relationships:** Where peak bodies have a good working relationship and are modelling collaborative behaviour. If professional collaboration were demonstrated at this level, it would be a positive impact or flow-on effect for the professions they represent.
- **Medicare Locals:** The introduction of Medicare Locals was seen to have potential to facilitate professional collaboration through building better localised relationships between health professionals. In particular, they would bring opportunities for:
  - Greater local planning to identify gaps in service delivery
  - Collaborating on consumer care and services based on community need
  - Pharmacists to get involved with other health professionals at a local level
  - Better relationships with Local Hospital Networks and facilitating collaboration with hospital pharmacists.
- **Collaboration 'champions':** Inclusion of individuals in the workforce who act as mediators between pharmacists and other health professionals e.g. GPs and the presence of 'champions' representing health professions at every level of an organisation. It is also important to have 'executive sign-off' and support from senior management on collaborative efforts.
- **Principles of change management:** Principles of change managements need to form the basis for any attempts to shift towards a model of professional collaboration. In particular, the implementation of a model needs to have a structured process, stakeholder engagement and indicators to track progress/measure success.

Infrastructure, systems and support

- **Shared health records:** New eHealth technologies, such as the national eHealth record system, will make it possible for information to be shared between GPs, pharmacists and other health professionals allowing for continuity of care. In countries where GPs and pharmacists are both able to access shared consumer records, such as the Netherlands and Taiwan, it appeared to facilitate collaboration and timely information sharing. In addition, other new technologies such as web-based portals and webinars were seen to be important mechanisms going forward.
- **Shared procedures and guidelines:** Regional/local level work plans or referral pathways developed between pharmacists and other health professionals will outline how collaboration will occur. For example, in the UK, all consumers are registered with one GP so that GP becomes the point of coordination and contact for providing primary health care to the consumer.

Communication and shared activities

- **Professional communication:** Regular and effective communication is imperative for professional relationship development, respect and collaboration. Communication is likely to happen when there is an established relationship, so it is particularly important in the beginning that communication be direct and face-to-face to help build rapport.
- **Co-location/shared activities:** For example where health professionals work in co-located/ nearby practices or have shared activities, such as regular multidisciplinary meetings to discuss a case.

Professional relationships

- **Better professional understanding of roles:** Where health professionals have a good understanding of other health professionals' roles thus reducing 'turf wars' and breaking down negative stereotypes of other health professionals. This understanding includes: building knowledge and understanding of health professionals' different skill sets; experience of working together successfully; and having clear roles and responsibilities.
- **Building professional trust/respect:** Through successful experiences of working together and understanding each other's value and contribution. For GPs, this was seen to be a key enabler as it was critical for them to trust that the pharmacist would contact them if the consumer had a problem.
- **Education and training:** Education and training was a key enabler beginning with interaction between professions at university e.g. interprofessional education and interdisciplinary work placements. This can be continued and sustained through the health professionals' career through further joint training.

Focus on the consumer

- **Focus on the consumer:** Placing the consumer at the centre of care should be the fundamental basis for professional collaboration. This can include greater engagement with consumer or consumer representatives at the national and local level.
- **Empowerment of the consumer:** Where the consumer is empowered, health literate and in control of their health care, this can help to drive this shift to a model of professional collaboration.

4.3.3 Barriers

The stakeholder consultations identified barriers to professional collaboration within primary health care – both from a general perspective but also included some specific examples from community pharmacy.

Policy, governance and funding

- **Funding mechanisms:** As it stands under the current funding system of Medical Benefits Scheme (MBS) and PBS payments, GPs and pharmacists are remunerated quite well and thus, there is little financial incentive to collaborate. These methods of funding also depend on consumer throughput so collaboration is often not a priority. Inadequate or inappropriate funding for collaborative efforts can create a barrier to collaboration.
- **Peak body relationships:** Where peak bodies have deeply entrenched and opposing views or professional rivalry or friction and operate in silos, it was reported that poor working relationships at this level can filter down to the organisational and professional levels.

Infrastructure, systems and support

- **Separation and size of practise:** Where practices are located in separate locations, it can often impact the ability of health professionals to work together, particularly, if they do not have the flexibility to meet physically with other health professionals. In addition, the size of practice can affect the continuity of care . with bigger practices or pharmacies, it can be harder to build one-on-one relationships and the continuity of care for consumers can sometimes be compromised.
- **Access to pharmacists in rural and remote areas:** Access to community pharmacy in rural and remote areas can be restricted and sometimes requires the community pharmacists to 'fly-in, fly-out' which can limited by funding and time restraints. Given this, professional relationships may be harder to build and maintain.
- **Limited information sharing technology:** Where there is no easy access to consumer information in a timely manner and where there are no technological structures or mechanisms in place to support sharing of information. This is also exacerbated in rural and remote areas where the availability of technological resources is sometimes limited.

- **Limited data**: Pharmacists, in particular, were identified as being a profession that were poor at collecting data which makes building an evidence base particularly hard. An evidence base is required to measure and benchmark collaborative efforts and for continuous improvement purposes.

Communication and shared activities

- **Professional communication:** A lack of networks and structures to support regular communication was reported. While it was identified that there is very basic communication taking place, significant effort is required to build and sustain relationships. Some health professionals still used outdated forms of technology such as fax or legacy IT systems that do not facilitate timely communication.
- **Workloads of health professionals:** Where health professionals have little time to work collaboratively with others due to existing workloads. In addition, from a practical perspective, the commercial aspect of running a community pharmacy means that community pharmacists can find it difficult to leave the pharmacy to collaborate with others.

Professional relationships

- **Role delineation/'turf wars':** 'Turf wars' exist between pharmacists, GPs and nurses and other health professionals where the expansion of a scope of work can create tension between health professionals. Particular issues in relation to pharmacy include the perceived level of training/ability that pharmacists have and community pharmacy being a 'free' health service and therefore, in direct competition with other health care services.
- **Lack of understanding of roles:** A lack of understanding of the roles, skills and expertise of other health professionals has implications for professional trust. It was seen that education and training for different professions often takes place in silos so health professionals often do not see the contribution others can make in the delivery of health care.
- **Perceived role of the GP**: This relates to the perception of the role of the GP as the centre of primary health care delivery and unilaterally in control of determining the course of care, even when other health professionals are involved.
- **Perceived role of the pharmacist**: This relates to the commercial approach and 'shopkeeper' image associated with the pharmacy business model which is detrimental to the perception of community pharmacists as health care providers. There is also a perceived lack of interest by community pharmacists to collaborate and a view that they work in relative isolation to other health professionals.

4.3.4 Elements of a preferred model

During the stakeholder consultations, elements of a preferred future model of professional collaboration for community pharmacists were identified by the stakeholders interviewed.

Policy, governance and funding

- **Funding and incentives:** The model needs to fund demonstrable evidence of collaboration for the benefit of the consumer. By funding service provision in this way, stress is taken off the supply model and puts a greater focus back on improving outcomes for the consumer.
- **Leadership from the professional bodies:** The vision for the way forward for collaboration needs to be demonstrated by and driven by the professional bodies.
- **Clear policy structures:** The model needs to have clear policy and funding structures so that collaboration is regulated and defined.
- **Evidence-based:** The model needs to be based on evidence and best practice.

Infrastructure, systems and support

- **Technology/eHealth:** The model needs to include advancements in technology for communication and sharing of information.

Communication and shared activities

- **Communication:** Systems and infrastructure are needed to support ongoing and regular communication to connect pharmacists to other professions.
- **Promotion of benefits/champions:** The model needs to promote the benefits of collaboration (including benefits for consumer, the health professional and the organisation) to health professionals, which may include the use of champions.
- **Co-location/bringing professions together:** The model needs to co-locate health professionals or bring them together on a regular basis e.g. in interdisciplinary professional development exercises.

Professional relationships

- **Building trust and professional respect:** The model needs to build trust and professional respect by identifying opportunities for change, being explicit about the roles of different professions, identifying common goals and getting buy-in and agreement on these. The model needs to encourage a significant cultural shift.
- **Collaboration at university:** The model needs to facilitate collaboration for health professionals at a university level with opportunities for them to build respect and understanding as early as possible.

Focus on consumer

- **Consumer-centred:** The model needs to be focused on the needs of the consumer and driving better consumer health outcomes.

4.4 Summary of key findings and implications for a model of collaboration

4.4.1 Key findings

From the stakeholder consultations, there are a number of key findings important for the development of a model of professional collaboration. These include:

1 A number of enablers and barriers to professional collaboration were identified through the consultation process (see Table 1); however these are notably very similar elements, which either act as enabler of collaboration at all levels or a barrier when perceived to be misaligned with local level needs.

Table 1: Enablers and barriers to professional collaboration as identified by stakeholder consultations

Enablers	Barriers
Supportive policy, governance and funding mechanisms e.g. good peak body relationships; introduction of Medicare Locals; funding structures incentivising professional collaboration	Unsupportive policy, governance and funding mechanisms e.g. funding model with little incentive to collaborate; peak bodies with professional rivalry and deeply entrenched and siloed views
Adequate infrastructure, systems and support in place e.g. shared eHealth records; shared policies and procedures	Limited infrastructure, systems and supports e.g. separation of professionals and size of practice; limited access to pharmacists in rural/remote areas; limited information sharing technology; limited data
Regular and effective communications e.g. through shared activities and face to face meetings	Lack of communication and shared activities e.g. little structures and networks to support communication; no time to work collaboratively due to existing workload

Enablers	Barriers
Building better professional relationships e.g. better understanding of roles and responsibilities; building trust and respect; interprofessional education and interdisciplinary training	Poor professional relationships e.g. role delineation/ 'turf wars'; lack of understanding about roles; perceived role of the GP; perceived role of the pharmacist
Focus on the consumer e.g. empowerment of the consumer and the consumer at the centre of care	

2 In addition, the consultations identified examples where professional collaboration is working well in Australia and internationally. Examples of professional collaboration reported to be working well were identified as having the following drivers:

- Necessity and interdependence of services, for example:
  - in rural and remote areas care delivery is impossible without clinicians working together
  - where multidisciplinary care planning for chronic diseases is necessary for the consumer
  - consumer centric services and care solutions based on local consumer health needs (e.g. UK model)
  - High risk consumers (e.g. mental health, elderly complex consumers).
- Proximity and connectivity of providers, for example:
  - multidisciplinary teams in hospitals
  - residential aged care facilities
  - where GPs and practice nurses are co-located (sometimes also Allied Health and pharmacy).
- Funding models that incentivise collaborative behaviours, for example:
  - medications reviews in a number of countries including Australia
  - multidisciplinary team care in some areas of Australia and internationally.

3 Anecdotal evidence and views of stakeholders provided throughout the consultations reported intergroup and intra-group attitudinal bias exists among Australian primary health professionals; that is, specific negative views expressed between and within a professional groups regarding specific groups of their colleagues was often based on stereotypes and attitudinal bias towards their qualifications and care delivery setting. These views were evident between professionals and the peak body representatives interviewed.

4 Necessary elements of a future model of professional collaboration identified through consultations included:

- leadership at the peak body level
- clear policy and funding structures
- evidence-based collaborative practices
- eHealth and technological solutions
- promotion of the benefits of collaboration
- building professional relationships (e.g. Co-location/bringing professions together regularly)
- interdisciplinary education
- a consumer-focused approach should inform the development of a future model of professional collaboration.

4.4.2 *Translating findings into practice*

In order to translate the findings identified through stakeholder consultations into practice, the proposed model of professional collaboration should:

- Build from the **success and learnings of existing collaborative practices** at a national level.
- Identify **an appropriate funding model** to provide incentives for collaborative practices, effective communication and strong relationships between professionals.
- Identify ways to **encourage improved understanding between health professionals** of each others' roles and capability and to challenge the deeply entrenched stereotypes of the role and value of fellow primary health care professionals.
- **Address interprofessional and intraprofessional attitudes and biases** that exist within and between groups by increased interactions between them. Leadership in this area will need to be encouraged, including acting as role models and demonstrating collaborative behaviours, and facilitating constructive behaviours and resolution of differences.
- The model of professional collaboration and its implementation should be **owned and driven by the professional peak bodies** and clinicians.
- Uphold the principle **of evidence-based practice** in the delivery of care and services.
- Include mechanisms that support ongoing **communication.**
- Address the **competencies and capabilities** required by health professionals to work collaboratively through interdisciplinary training and education at university and beyond.
- Place the **consumer at the centre of the model** of health care delivery and decision-making.

Some of these actions and principles will require structural change (for example, for peak bodies to drive the professional collaboration initiative); others will require changes at the level of individual health care providers, such as addressing negative attitudes and bias. Similarly, some actions can be undertaken immediately (providing leadership, developing policy) while others will be addressed through and during the actual implementation of the proposed model.

5 The literature review and mapping exercise

This section describes the literature review and mapping exercise including its purpose, approach, key findings (including enablers and barriers to professional collaboration and principles, models and examples of existing models in primary health care; and change management considerations), and the implications of the key findings for a future model of collaboration.

5.1 Purpose

The purpose of the literature review and mapping exercise was to identify and develop an evidence base of the enablers and barriers of professional collaboration. This evidence base, including best practices, was used to inform the development of the proposed model of professional collaboration.

The literature review aimed, through exploring research and best practice literature, to identify examples of:

1. Collaboration in primary health care which involve community pharmacy and other health professionals, both in Australia and internationally and

2. Enablers of and barriers to collaboration by community pharmacists in primary health care.

The mapping exercise, informed both by research and stakeholder consultations, documented relevant case studies of existing multidisciplinary care arrangements in Australia and internationally.

5.2 Approach

For the literature review, an exhaustive search of relevant sources of information was completed using agreed search terms to identify literature relating to: (1) known enablers of and barriers to professional collaboration in primary health care; and (2) examples of collaboration in primary health care which involved community pharmacy and other health professionals, both in Australia, and internationally.

The electronic databases, academic journals and websites which were used in the literature search are listed in Table 2 and the search terms are outlined in Table 3. Both the list of search terms and sources were agreed by the Advisory Panel on 26 September 2011. For more information about the key findings and implications as well as the annotated bibliography with 95 articles that identified enablers of and barriers to collaboration in primary health care and full case studies of all the examples of collaboration identified, please refer to the *Professional Collaboration Literature Review and Mapping Report* (5CPA, 2012).[11]

Examples of collaboration between health professionals in primary health care focused mainly on collaboration between community pharmacists and other health professionals e.g. GPs, nurses or Allied Health professionals. However, other relevant examples of collaboration between health professionals that did not involve a community pharmacist i.e. between GPs and nurses or between GPs and Allied Health professionals were also identified.

[11] http://www.5cpa.com.au/sites/5CPA/Initiatives/Research_and_Development/Fifth_Agreement/Fifth_Agreement/RFT2010_11-05%20Professional%20Integration.page

Table 2: Database and websites used during search

Database/ Journal	AccessPharmacy, Apais-Health Database, Australian Digital Thesis, Biomed Central, CINAHL, Clinical Information Access Portal, Cochrane Library, Cochrane Reviews, Dissertation Abstracts EBM (ACP Journal Club, CLHTA, CCTR, CLEED, Cochrane DSR, DARE, CLCMR), EMBASE, Health and Society Database, Health Collection, Informit, International Pharmaceutical Abstracts, Journal of Professional Care, MEDLINE, PsychINFO, Pubmed, Science Direct, Scirus, Scopus, Web of Science.
Search engine/ website	American Pharmacists Association, Australian Institute of Health and Welfare, Australian Resource Centre for Health care Innovations, Australian Commission for Safety and Quality in Health, Canadian Pharmacists Association, Clinical Excellence Commission, Commonwealth Fund, Department of Health and Ageing, Google, Google Scholar, International Pharmaceutical Federation, National Library of Australia, National Institute for Health and Clinical Excellence UK, OECD, Pharmacy Guild of Australia, Pharmaceutical Society of Australia, Royal Pharmaceutical Society, World Health Organization.

Table 3: Keywords used during the search (listed in no particular order).

1	'professional collaboration' and 'enablers' or 'barriers' or 'challenges' or 'facilitators'
2	'community pharmacists' and 'general professionals' or 'allied health' or 'nurses'
3	'cross-functional team'
4	'integrated delivery of health care'
5	'interdisciplinary care'
6	'professional learning' or 'professional communication' or 'professional relations'
7	'multidisciplinary care' or 'multidisciplinary health care' or 'multidisciplinary team' or 'multidisciplinary care team' or 'multidisciplinary approach'
8	'consumer care team'
9	'pharmacist' and 'general professionals' or 'allied health' or 'nurses'
10	'community pharmacist' and 'primary care' or 'primary health care' or 'enhancing primary care'
11	'professional integration' or 'professional collaboration' or 'collaborative care' or 'coordinated care'
12	'teaming'

5.3 Discussion of key findings

The following represents a summary of key findings from the *Professional Collaboration Literature Review and Mapping Exercise Report*; including enablers and barriers to professional collaboration, principles of collaboration in primary health care, models of professional collaboration in primary health care, existing collaboration between pharmacists and other health professionals across the health continuum and considerations for change for a future model of professional collaboration.

5.3.1 Enablers to and barriers of professional collaboration

The literature review explored factors or elements likely to improve or contribute to the success of collaborative practices ('enablers') as well as any factors or elements likely to halt or inhibit their success ('barriers'). In doing so, it was found that the enablers and barriers, similar to those identified during stakeholder consultations, could be categorised under four main themes:

- Policy, governance and funding
- Infrastructure, systems and supports
- Communication and shared activities
- Building professional relationships.

Good **policy, governance and funding** enable professional collaboration. Legislation and policy can support collaborative practices backed with equitable and fair funding. The leadership, structure and culture of an organisation can provide clarity and flexibility to support these practices. On the other hand, organisations that have embedded hierarchies and divisions can provide challenges for collaborative practices. A lack of funding was also cited as a principle barrier. Meanwhile, changes in policy and legislation to support collaboration can take effort and time.

Infrastructure, systems and supports that encourage professional collaboration include: health professionals being co-located or working in close physical proximity, an appropriate physical layout e.g. one that has enough space for collaboration to occur, shared goals and protocols, common tools and information technology systems such as electronic health records, and sufficient time and resources to collaborate. Conversely, the physical isolation of community pharmacies, a lack of time and resources, and a lack of referral pathways are detrimental to collaboration, as is when consumer information is not shared in a timely or effective manner.

Communication is obviously a key component of effective collaboration. Sufficient opportunities for communication, feedback, and **shared activities,** such as multidisciplinary meetings on a regular basis, should be complemented by shared data and effective communication strategies to facilitate collaboration between health professionals.

Finally, at the individual level, **building professional relationships** is needed. This is based on: trust; respect; understanding; commitment; readiness to change; and clear roles and responsibilities. Interdisciplinary learning and training such as team-building activities and ongoing collaborative skills training can enable collaborative practices. However, such factors as: power differences between team members; negative stereotypes; a lack of understanding of roles and responsibilities; and a fear or unwillingness to change can act as barriers.

5.3.2 Characteristics of collaboration in primary health care [12]

Although there appears to be an absence of conceptual clarity about the nature of collaboration (Suter et al, 2009), the literature review identified a number of key and consistent characteristics that are important for understanding collaboration and what it may include in the context of primary health care.

[12] In the published Professional Collaboration Literature Review and service mapping report these items were referred to as Principles . As the project has now agreed principles for the model of collaboration this use of terminology was revised.

Despite this limited consensus on a defined model of collaboration between health professionals in primary health care, a number of consistent key characteristics emerged from the literature. These principles suggest that professional collaboration involves:

- **Two or more health professionals:** The nature of collaboration implies the necessary involvement of two or more professionals (Oxman, 2008) in providing care to the consumer to undertake a common task characterised by a collegial-like relationship (D'Amour and Oandasan, 2005).
- **Collective processes and actions:** Collaboration is the process of multiple health professionals working together collectively i.e. professionals structuring a collective action towards consumers' care needs (D'Amour, 1997). The principle of collective process is linked closely to the concept of 'sharing' which includes shared responsibilities, decision-making, values, planning and interventions, and shared perspectives and knowledge (D'Amour and Oandasan, 2005).
- **Meeting consumer's complex needs:** WHO (2010) identified that collaborative practices in health care are especially important when input is required from more than one health professional such as for individuals with chronic disease. Coordination of care is necessary for improving health outcomes more generally (Oxman, 2008).
- **Continuity of care:** Collaboration occurs within and between professions, with health professionals communicating and collaborating in and across different settings along the continuum of consumer care with continuity of care extending to shared information, management and relationships (D'Amour and Oandasan, 2005).
- **Communication:** Effective communication and knowledge exchange is both an enabler for collaboration as well as an outcome of successful collaboration in health care (Oxman, 2008).
- **Consumer focus and involvement:** A focus on the consumer and ensuring their involvement is an important principle in the collaboration between health professionals (Tieman et al, 2007) while also encouraging consumers to take an active participatory role in their coordinated care as their participation can form part of the team's collaborative dynamic (D'Amour and Oandasan, 2005).

These characteristics were an important consideration for the development of the proposed model collaboration and more generally, should be considered as part of the necessary foundation for collaboration between pharmacists and other health professionals in primary health care.

5.3.3 International models of professional collaboration in primary health care

Existing international models of professional collaboration in primary health care were identified to inform the development of a future model. The models described below are:

- the Framework for Enhancing Interdisciplinary Collaboration in Primary Health Care
- the International Pharmaceutical Federation – Levels of Collaborative Practice
- Collaborative Working Relationships between pharmacists and GPs

The Framework for Enhancing Interdisciplinary Collaboration in Primary Health Care

The Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative in Canada (2005) proposes a framework of structural and process elements required to support collaborative primary health care. It is a useful reference in considering the characteristics of a collaborative approach to primary health care that explores enablers, barriers and principles of collaboration; however, it would require analysis for its adaptation to the Australian health system.

The framework states that seven elements must be present in order to sustain a health system that maximises the benefits of interdisciplinary collaboration. The seven inter-related elements of the framework are to be considered as a whole as illustrated in Figure 6:

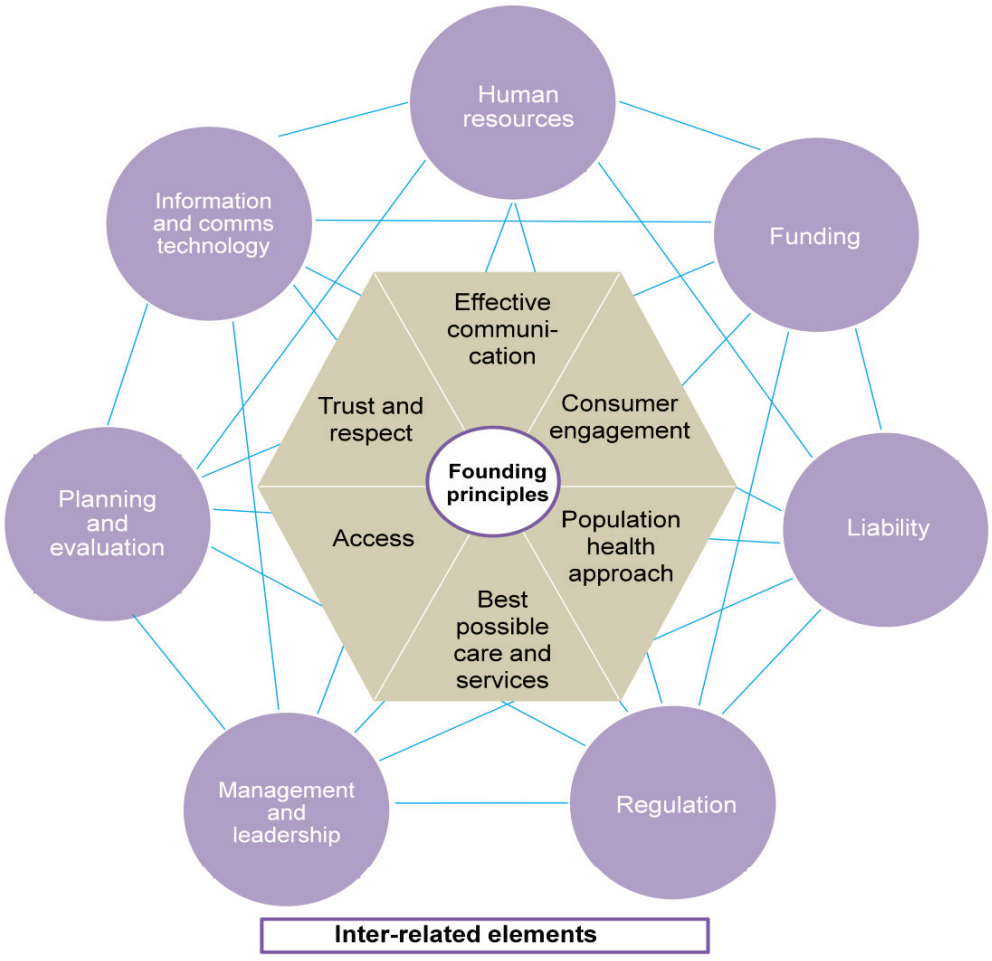
- The effective use, availability and distribution of human resources for health care and training, including recruitment and retention activities and education for collaboration and other key areas such as consumer engagement
- Adequate and reliable **funding** which may include innovative funding models that incentivise collaboration.
- A proper consideration of **liability**

- Supportive **regulation** of health professionals and including collaboration between regulators
- Information and communications technology to support collaboration
- A **management and leadership** committed to a vision for collaborative primary health care
- Strong administrative support for **planning and evaluation** of primary health care and to measure the performance of interdisciplinary collaborative practices.

These seven elements are founded on a set of six principles which are critical to establishing collaboration and teamwork to achieve the best health outcomes for consumers:

1 Consumer engagement
2 Population health approach,
3 Best possible care and services
4 Access
5 Trust and respect
6 Effective communication

Figure 6: Interrelated elements and founding principles of the Framework for Enhancing Interdisciplinary Collaboration in Primary Health Care



International Pharmaceutical Federation – Levels of Collaborative Practice

The International Pharmaceutical Federation (FIP) Levels of Collaborative Practice (2009) proposes a model of collaboration between pharmacists and other health professionals that has five distinct levels of collaboration as illustrated in Figure 7.

Level 1 – Minimal contact between pharmacists and health professionals

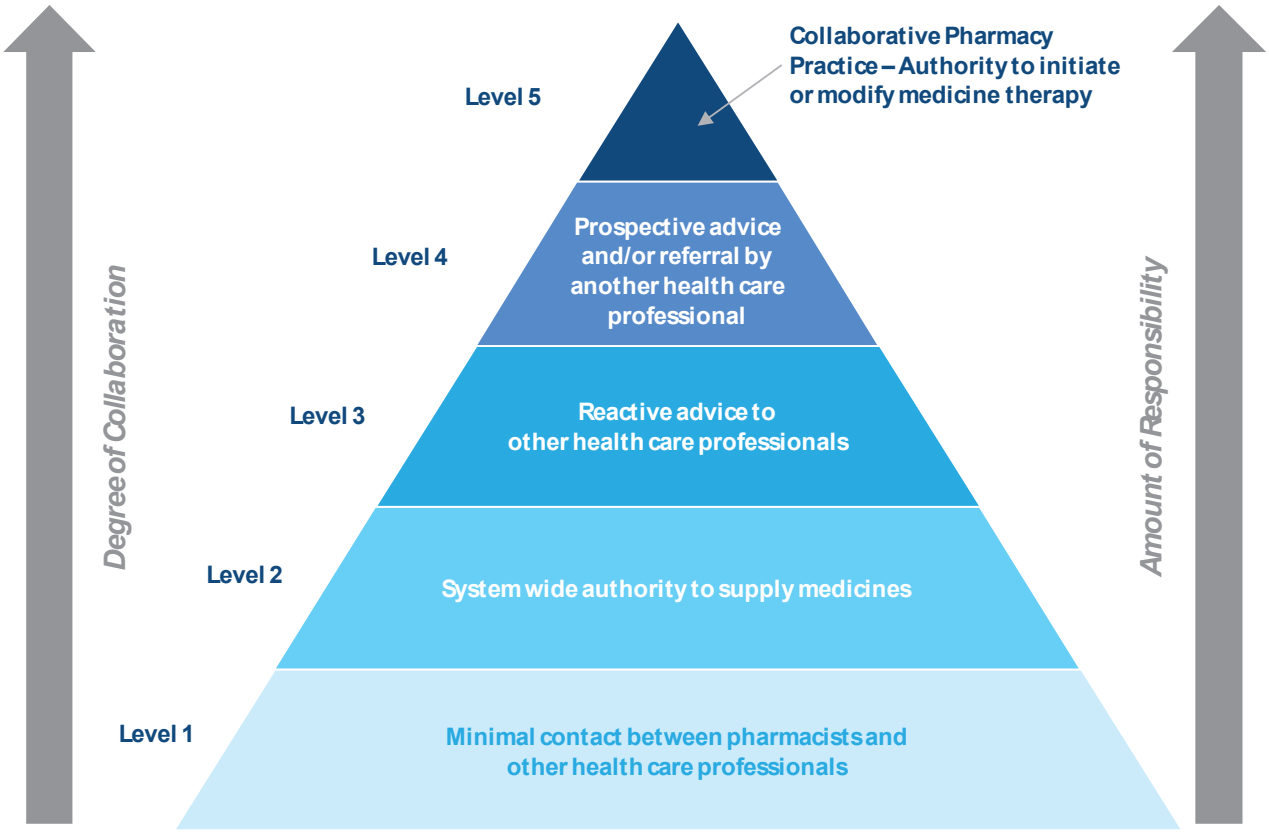
Level 2 – System-wide authority to supply medicines

Level 3 – Reactive advice by pharmacists to other health care professions

Level 4 – Prospective advice and/or referral by another health care professional

Level 5 – Collaborative Pharmacy Practice: Authority to initiate or modify medicine therapy.

Figure 7: The Levels of Collaborative Practice as proposed by the International Pharmaceutical Federation



All levels may be present within the same health system; however, the higher levels of collaboration are less common and often involve advanced professionals. It is likely that the pharmacy profession would need to move from one level to the next in a step-by-step manner; it is highly unlikely that pharmacists would be able to move from Level 1 directly to Level 5 without development at some or all of the intermediate levels. The degree of collaboration and amount of responsibility increases at the same time as advancing from lower levels to higher ones.

The attainment of Collaborative Pharmacy Practice at Level 5 assumes that pharmacists are an integral member of the health care team and work collaboratively with other team members to provide appropriate advice on the initiation or modification of medicine therapies. It also requires that pharmacists have access to consumer's medical records and are able to record the interventions appropriately.

Collaborative Working Relationships between pharmacists and GPs

A commonly used model of collaboration for pharmacists is the Collaborative (CWR) model proposed by McDonough and Doucette (2001) which uses five stages to describe the development of working relationships between pharmacists and physicians in an area where traditionally, collaboration between the two professional groups has been difficult to achieve. The model advances from brief interactions on routine matters (Level 0 and 1) to mutually beneficial partnerships in which both parties have clearly defined roles and consumer care responsibilities (Level 5) as illustrated in Figure 8.

Stage 0 – Professional awareness

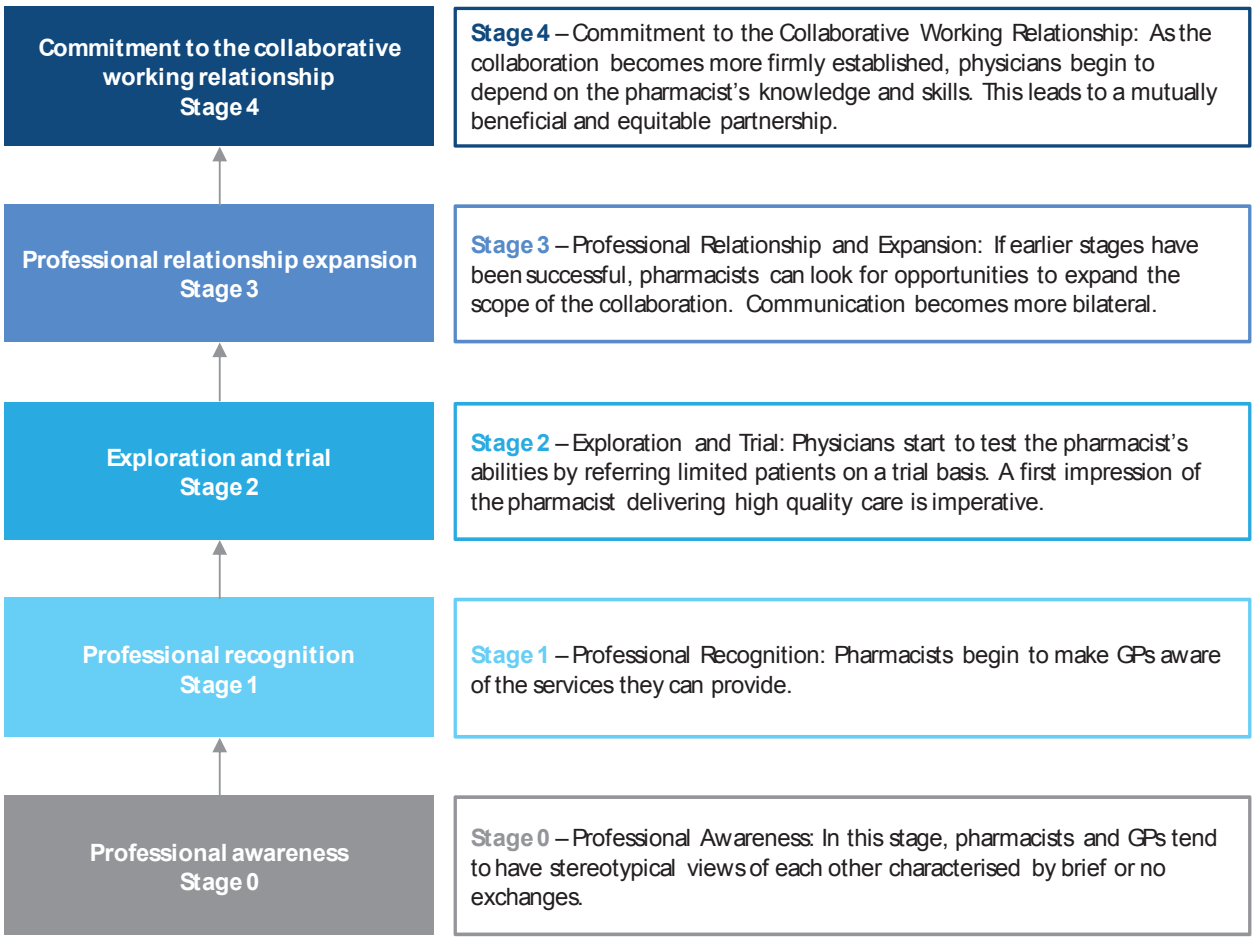
Stage 1 – Professional recognition

Stage 2 – Exploration and trial

Stage 3 – Professional relationship expansion

Stage 4 – Commitment to the Collaborative Working Relationship

Figure 8: Model for Pharmacist-Physician CWR



Existing collaboration between pharmacists and other health professionals across the health continuum were examined. The literature review identified the four most common areas in the continuum of health care services where professional collaboration occurs between community pharmacists and other health professionals in primary health care.[13] These areas were used as a framework to review and demonstrate examples of collaborative practices. The four areas are:

- Health promotion and prevention
- Chronic disease management
- Medicines review and management
- Palliative care

These areas correspond to the spectrum of health care services that pharmacists can provide for consumers, as identified by the Pharmacy Guild in their *Change Management in Pharmacy* project funded under the 3CPA (Pharmacy Guild of Australia, 2006). This spectrum named six areas of health care: prevention, early detection, diagnosis and assessment, treatment, rehabilitation and palliation. Examples of activities that fall within these four areas are illustrated in Table 4.

Table 4: Areas of professional collaboration

Health Area	Health Services	Examples of activities
Health promotion and prevention	• Includes aspects of prevention (e.g. flu vaccinations), early detection (e.g. blood pressure and cholesterol control) and diagnosis and assessment (e.g. anticoagulation management)	• Flu immunisation and vaccination • Anticoagulation management • Blood pressure control • Cholesterol management • Osteoporosis screening • Education and awareness about smoking, nutrition etc.
Chronic disease management	• Includes aspects of treatment and rehabilitation	• Diabetes management • Asthma and COPD care • Cardiovascular disease management • Mental Health Community Teams • GP management plans
Medicines review and management	• Includes aspects of treatment and rehabilitation	• Home Medicines Review • Residential Medication Management Reviews
Palliative care	• Includes aspects of palliative care	• Medicines Review and Management • Education and Awareness

5.3.4 Considerations for change in collaborative practices

The literature review also identified considerations for supporting significant change, in other words, a shift from the current practice model to one of effective professional collaboration. It is proposed that change of this magnitude will need to employ well-established and evidence-based change management strategies to ensure its success. Roberts (2007) considered that change in community pharmacies is difficult as it involves a 'fragmented network of individual organisations'.

Using Kotter's 8 steps for change (1996), a widely accepted framework, Tsuyuki and Schindel (2008) proposed common steps to support change towards professional collaboration. Although the principles of change management were developed from a business perspective, Tsuyuki and Schindel (2008) proposes that many of the same principles are highly applicable to health care and pharmacists. The proposed framework provides a useful and practical guide for discussing ways of supporting changes in practice in pharmacy and allows pharmacy organisations and pharmacists to focus on their

[13] While health promotion and prevention does not always sit within the primary health care setting, we have included them for the purposes of this project in the continuum of consumer care.

role in changing the way in which pharmacies operate and to apply these concepts in addressing change to collaborative practices. The framework could equally be applied to other health professionals. The eight steps are described in Table 5.

Table 5: Tsuyuki and Schindel (2008) 'Steps for supporting practice change in pharmacy'

Step	Description
Step 1: Establish a sense of urgency	Community pharmacists must feel a need to carry out change. Without a compelling reason to change, they will have little motivation to do so. The sense of urgency needs to be established at a health care system level, highlighting the issues of an ageing population, increasing prevalence of chronic diseases, gaps in the delivery of health care and changes to legislation.
Step 2: Form a powerful guiding coalition	Major change initiatives require strong leadership which may not arise from a single individual or organisation. In changing pharmacy practice, leadership is required throughout the entire spectrum of health care, from national, state and local governments and from professional bodies to local pharmacies and individual pharmacists as well as to other health professionals and consumers.
Step 3: Create a vision for pharmacy	A vision for pharmacy needs to be created. It should be appealing and easy to communicate. Without a clear vision, efforts towards change can disintegrate into unrelated, small projects that do not have the intended effect. In contrast, when there is a compelling vision, it can bring people together and motivate them to change.
Step 4: Communicate the vision	A common problem encountered in change is the poor communication of the vision. Communication of the vision has to be articulated well and aligned to the behaviours exhibited by leaders driving the change. Communication strategies also need to be extensive and ongoing to ensure a sense of continuity.
Step 5: Remove obstacles to the new vision	To advance the vision and drive change, there needs to be an awareness of the obstacles to the new vision and progress made towards removing them. If pharmacists see leaders taking concrete steps to address such obstacles, they will feel more empowered to make changes in their own practice.
Step 6: Plan and create short-term wins	Changes in practice involving individual pharmacists, pharmacy organisations, the government and other health professionals can often take years to achieve. This can lead to a loss of momentum. Planning and creating short-term wins is important to provide evidence of the benefits of the new vision within a short period of time.
Step 7: Consolidate improvements and produce more change	Until changes become deeply embedded into pharmacy culture, regressing to old behaviour is common. Leaders of the change initiatives will need to build on what has been achieved and learned so far and continue the momentum to change policies, systems and processes that do not promote the vision.
Step 8: Institutionalise new approaches	Practice change has to be institutionalised so that it becomes the norm in pharmacy culture. This requires extensive communication. Practice change will only become permanent when it becomes part of the shared values and social norm of the profession.

5.4 Summary of key findings and implications for a model of collaboration

5.4.1 Key findings

From the literature review and mapping exercise, a number of key findings were identified to inform the development of a model of professional collaboration, these included: These include:

- The enablers and barriers to professional collaboration identified through the literature review and mapping activity were consistent with those identified through the stakeholder consultations.
- While there is a significant amount of existing research on professional collaboration and related concepts, there is at the same time a lack of conceptual clarity about professional collaboration.
- Several examples of existing Australian and international models of professional collaboration in primary health care were identified as a useful basis for adaptation. Of note were:
  - *The Framework for Enhancing Interdisciplinary Collaboration in Primary Health Care* proposes a framework of seven structural and process elements that must be present in order to sustain a health system that maximises the benefits of interdisciplinary collaboration. These seven elements are founded on an agreed set of six principles considered critical to establishing collaboration and teamwork.
  - *The Levels of Collaborative Practice* proposes five levels of collaboration between health professionals and pharmacists and while all five levels may be present within a health care system, the higher levels are less common and movement from lower to higher levels is in a stepwise manner.
  - *Collaborative Working Relationships between pharmacists and GPs* uses five stages to describe the evolution of this relationship from communication on routine matters (Level 0 and 1) to mutually beneficial relationships with clearly defined roles and responsibilities (Level 5).

Each of these three models required the development of professional trust through consistent interaction between health professionals. The common themes across these models were:

- The process was iterative and required some basic foundational elements and 'rules of engagement' such as supportive policies and principles
- That successful collaboration included joint decision making processes
- Policy or regulation based incentives for interaction usually only progressed individuals part way through the collaborative evolution. Moving up the scale from communication to collaboration required the establishment of a trust relationship with shared decision making, clear roles and a shared benefit.
- Basic consumer information is shared across providers – without this shared decision making is impossible.
- Similarly, the change model proposed by Tsuyuki and Schindel (2008), based on Kotter's (1996) 8 steps of change, identifies that a model for changing structures, behaviour and processes requires a step-by-step change management process. The necessity for leadership was particularly noted, as was the usefulness of forming a powerful coalition to guide change. The coalition would include the entire spectrum of health care from national to state and local levels and from professional bodies to individual pharmacists.

For detailed findings from the literature review, please refer to the *Professional Collaboration Literature Review and Mapping Exercise Report* (5th Community Pharmacy Agreement, 2012).

5.4.2 *Translating findings into practice*

The key findings identified through the literature review and mapping exercise were used to inform the development of the proposed model for professional collaboration. In particular, the findings translate to the following actions:

- **Clarify what constitutes professional collaboration** and how this is more than just communication between professions.
- Establish the foundation of **structures and processes** for achieving successful collaboration. This includes national and local infrastructure to provide governance.
- Provide a **mechanism for local-level practice to inform national and state policy decision-making, funding models and distribution**. This should represent a powerful guiding coalition across primary health care that includes national, regional and local levels and from professional bodies to local practices to individual health care professionals.
- Encourage **information sharing and communication** between primary health care professionals. While eHealth is an opportunity to share information it should not replace other forms of communication.
- **Define roles and responsibilities** of health professionals and support ongoing related conversations between health care professionals.
- Utilise prevention activities, chronic disease management and medicines review and management **as starting points for further development** of the model.

6 Primary Health Care Professionals Survey

This section describes the approach and findings of the Primary Health Care Professionals Survey including its purpose, approach, key findings (including demographics, frequency and preferred mode of communication, enablers, barriers and attitudes towards collaboration), and the implications for a future model of collaboration.

6.1 Purpose

The purpose of the *Primary Health Care Professionals Survey* was to gain the perspectives of primary health professionals, through a statistically relevant sample, in regards to:

- Their degree of previous experience with professional collaboration and multidisciplinary teamwork, including barriers to and enablers of collaboration
- Suggested mechanisms for professional collaboration e.g. for communication
- Perceived benefits of professional collaboration
- The survey respondents' readiness and willingness to change and their perception of the level of support and resources required for change.

6.2 Approach

6.2.1 Survey development

The *Primary Health Care Professionals Survey* was a web-based survey. The questions were developed based on findings from the first two phases of the *Professional Collaboration* project i.e. the stakeholder consultations and the literature review and mapping exercise.

Information obtained through the first two phases of the project, regarding commonly identified enablers of and barriers to professional collaboration, were used to form part of the survey. This allowed a validation of these enablers and barriers and particularly, the prioritisation of which ones are most important and to which professions.

The survey was developed to include a component on health professionals' attitudes towards professional collaboration, as it was important to establish a baseline of current views. The questions were adapted from a range of existing and validated questionnaires on organisational change readiness and willingness. Demographic questions were included to ensure data was from a representative sample of professionals in primary health care in Australia and to gain a greater understanding of the characteristics of the survey respondents, such as their area of specialisation.

The following key research questions were used to inform the development of the survey questions:

- The demographic characteristics of survey participants, e.g. profession, location, age, place of graduation, years in primary health care, area of specialisation, location and type of workplace
- The extent survey respondents are currently collaborating with other health professionals, in particular, with regards to:
  - Frequency of collaboration e.g. daily, weekly
  - Preferred mode of communication, e.g. email, phone, fax
- The perceived benefits of professional collaboration e.g. for the consumer, for the health care professional
- What are the enablers and barriers to collaboration for health professionals?
- Current attitudes and behaviours towards collaboration, in particular, their levels of readiness and willingness to collaborate
- What levels of support, resources and education are required to support collaboration?

The survey was piloted with 19 representatives from each of the target respondent groups – GPs, pharmacists, nurses and Allied Health professionals. The purpose of the pilot was to test the usability of the online survey tool and to validate the appropriateness of the survey questions. The results of the pilot informed the further refinement of the survey tool.

An initial draft of the survey was reviewed by the Advisory Panel to validate that the questions met the survey objectives. The survey then underwent further refinement based on feedback by the Advisory Panel. For the full list of questions included in the survey, please refer to Appendix C

6.2.2 Target respondents

A national sample of health professionals practicing in primary health care were targeted for the survey, as shown in Table 6.

Table 6: Target respondents for the survey

Community/Consultant Pharmacists	General Professionals	Nurses	Allied Health
• Community Pharmacist • Consultant Pharmacists	• General Professionals	• Enrolled Nurse • Registered Nurse • Nurse Practitioner • Practice Nurses • Midwife • Disease State Educator (i.e. asthma, diabetes)	• Dentist • Dietician • Occupational Therapist • Physiotherapist • Podiatrist • Social Worker

The methodology of the survey aimed to achieve a sample size of primary health care providers which would provide sufficient precision and power within each profession and remoteness category; as such the target was 380 participants per stratum for a total of 3040 valid responses. Table 7 shows the actual number of survey participants by professional cohort and remoteness (ARIA).

Table 7: Sample stratification by remoteness

	Remoteness		
	Major Cities	Regional to Very Remote	Total
Pharmacists	374	354	728
GPs	378	364	742
Nurses	380	376	756
Allied health	382	375	757
		Grand total:	2983

6.2.3 Survey administration

The *Primary Health Care Professionals Survey* was open for 12 weeks from the 8 March 2012 to 8 June 2012. Administration of the survey was through an online survey tool. The survey was self-administered with a set of instructions on the first page of the survey. The survey took approximately 10–15 minutes for GPs, nurses and Allied Health professionals to complete and up to 20 minutes for pharmacists due to further detail requested.

Formal consent was not required for the survey. However, a disclaimer was included on the front page of the survey stating that by continuing to complete the survey, the participant was consenting to take part and to have read the information provided.

6.2.4 Survey promotion and distribution

Methods of survey promotion and distribution of the survey were developed and outlined in a communications plan. Consistent messages about the purpose of the survey and incentives to participate were also developed and included in the plan. The communications plan was reviewed by the Advisory Panel for approval ahead of the roll-out of the *Primary Health Care Professionals Survey*.

There were two target audiences for the survey communications. The primary target audience were health professionals (as outlined in Table 7). The secondary target audience were peak bodies representing the targeted health professionals. Promotion of the survey was implemented in three stages and various platforms were utilised for distribution of the survey. The three stages included:

1 Pre-survey release – to obtain peak body support in the promotion and distribution of the survey and to raise awareness of the survey.

2 Survey implementation– to promote the commencement of the survey period and to encourage participation.

3 Post-survey – to thank participants and to inform participants of their relevant incentives (incentives were provided to those who adequately completed the survey).

Peak bodies were contacted to garner support for distribution of the survey link to their members. Promotion was through various platforms including through websites, e-newsletters, fax and emails. At various points during the survey implementation, there were follow-up actions to contact supportive peak bodies to further encourage and remind their members to complete the survey.

Several professional conferences, either profession-specific or for primary health professionals, were identified as being good opportunities for survey promotion. Flyers with information on the *Professional Collaboration* project and survey were distributed at the conferences.

The *Primary Health Professionals Survey* was officially launched at the Guild's Annual Australian Pharmacy Professional National Conference. The promotion of the survey was through mention in the opening address, distribution of the flyer, and presence at the Guild booth. The survey was available to be completed on iPads and computers available at the booth; PwC staff were on hand to answer questions about the *Professional Collaboration* project or about the survey more specifically.

Ongoing promotion of the survey throughout the implementation included the establishment of a helpdesk (both an email address and phone line) to answer any questions about the survey in a timely manner and through peak bodies and Medicare Locals.

Mailing lists of contacts details of primary health professionals were purchased for distribution of flyers promoting the survey. These were sent to a sample of pharmacists, GPs, nurses and Allied Health professionals across metropolitan, regional, rural and remote areas. Each flyer was tailored to the specific profession group.

Survey respondents were asked how they had heard about the survey with the most common channel reported as being:[14]

- Peak body emails (36%)
- Post distribution of flyers (15%)
- Peak body newsletters (14%)

The least reported channel the survey was accessed via was:

- Fax (including peak body fax) (3%)
- Distribution of flyers at conferences (4%)

[14] This survey question was not mandatory and not all respondents provided an answer. The results presented are based on frequency of methods of distribution reported and are not representative of the entire respondent sample.

From these results it is possible to conclude that engaging peak bodies in endorsing and promoting the survey to their members via email and advertising the survey in their regular communications, such as newsletters, was the most effective single channel for responses. This is potentially due to these two options being electronic and convenient for participants. Targeted post distribution of flyers to the workplace and home of health professionals was also reported to be an effective method of raising awareness of the survey.

Fax distribution of the flyer promoting the survey was the least effective method, even when the fax came from the peak body to their members. Flyer distribution at professional conferences was relatively costly compared to other methods of distribution and not as effective. This is potentially due to the amount of other promotional material distributed at conferences lessening the cut-through of the survey flyer.

These findings are useful for future engagement of health professionals in primary health care in Australia when attempting to increase survey responses. The uptake of email and website based promotion as opposed to the traditional method of fax may also be a useful insight for peak bodies.

Following the close of the survey, all peak bodies involved were notified and thanked for their assistance, incentives including payments to GPs made, and iPad winners announced (see survey incentives below).

6.2.5 Survey incentives

The Research Team consulted with a number of stakeholders when determining appropriate incentives to increase survey response rates including peak bodies of the targeted health professions. This provided insight as to what incentives had been effective in engaging which particular health professional group in the past. This insight and other research informed a proposed incentive plan submitted to the Advisory Panel.

The use of incentives for completing the survey followed a two-pronged approach. Previous successful techniques and research (VanGeest, 2007; Deehan et al, 1997) to engage GPs in completing surveys included making a small payment for their participation. Accordingly, GPs who completed the survey received payment for the amount of $50 paid by the Research Team. For pharmacists, nurses and Allied Health professionals, all survey respondents were entered into a draw for one in five iPads (per profession group, a total of 15 iPads).

Interestingly, not all GPs expected nor requested payment for completion of the survey, with 32% of GP survey respondents never requesting payment.

6.3 Survey analysis and results

6.3.1 Survey analysis

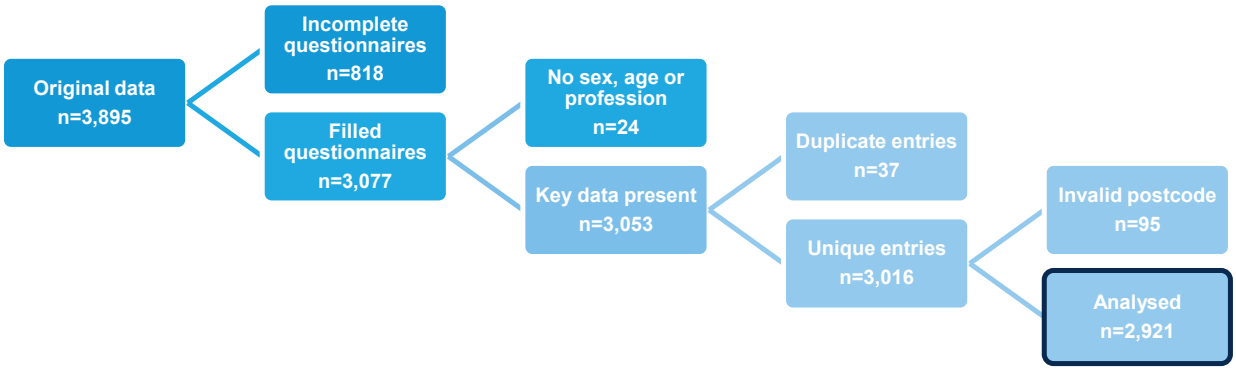
Data for the *Primary Health Professionals Survey* was de-identified, collated and analysed by biostatisticians at the George Institute for Global Health in collaboration with the Research Team. The data analysis was presented in a technical report which details the types of analysis and assumptions that were used. Analysis utilised a variety of statistical methods including:

- Descriptive statistics presenting the results for each question e.g. mean and standard deviation for continuous variables or frequency for categorical variables. The mean was presented for each question overall as well as separately for each of the four profession groups (pharmacists, GPs, nurses and Allied Health professionals) and by remoteness (major cities, regional to very remote areas).
- Questions addressing attitudes and behaviours towards collaboration were combined into a global "collaborativeness" score using principal component analysis.
- Hypothesis testing to determine whether there were statistically significant relationships between key factors and the overall "collaborativeness" score using univariate and multivariate linear models.

6.3.2 Response rates

There were a total of **3,895 responses** to the *Professional Collaboration Primary Health professionals Survey*. The sample of 3,895 responses went through a data cleaning process and included the removal of invalid entries. The cleaned sample for inclusion in the analysis was a total of **2,921 responses** (see Figure 9).

Figure 9: Data cleaning flow



To ensure sufficient numbers within each profession and remoteness area, the survey purposely oversampled regional and remote areas and certain professions. To obtain correct estimates at the overall population level it was therefore, necessary to "redress" the survey to make it representative of the Australian population. This was done by applying weights to each participant such that the distribution of participants by profession and remoteness in the survey reflects the distribution of profession and remoteness in the 2006 ABS census. The numbers presented (weighted survey data) can therefore be extrapolated to the Australian population. Please see Table 8 for the distribution of sample by area and profession before and after weighting. For the further breakdown of the sample as per the ABS 2006 Census, please refer to 9.3Appendix DSurvey sample weighting

The majority of survey respondents were located in major cities (63%) and a smaller proportion was located in regional and very remote areas (37%). Overall, the survey included 26% Allied Health Professionals respondents, 28% nurse respondents, 15% GP respondents and 32% pharmacist respondents. Survey respondents were primarily female (72%) with a minority of male (28%). In particular, nurse respondent (96%) and allied health professionals (78%) were primarily female. Survey respondents were fairly evenly distributed throughout the middle age groups 25-34 (25%), 35-44 (22%) and 45-54 (29%).

After weighting, the proportion from major cities was increased to 73% which reflects the true distribution across the Australian population. Similarly, the distribution of professions was changed to 41% Allied Health Professionals, 29% nurses, 19% GPs and 11% pharmacists; thus increasing the contribution of allied health professional who were underrepresented among the survey responders and reducing the contribution of pharmacists who were overrepresented.

Table 8: Distribution of sample before and after weighting

Survey data (unweighted)

	Major cities	Regional to very remote	All regions
Pharmacists	595 20.4%	333 11.4%	928 31.8%
GPS	310 10.6%	129 4.4%	439 15.0%
Nurses	469 16.1%	337 11.5%	806 27.6%
Allied health	452 15.5%	296 10.1%	748 25.6%
All professions	1,826 62.5%	1,095 37.5%	2,921 100.0%

Survey data (weighted)

	Major cities	Regional to very remote	All regions
Pharmacists	238 8.2%	82 2.8%	321 11.0%
GPS	428 14.6%	125 4.3%	553 18.9%
Nurses	532 18.2%	311 10.6%	842 28.8%
Allied health	928 31.8%	278 9.5%	1,206 41.3%
All professions	2,125 72.8%	796 27.2%	2,921 100.0%

All data presented in the remainder of this section is based on weighted data.

6.3.3 Demographics

The majority of survey respondents were located in major cities (73%) and a smaller proportion was located in regional and very remote areas (27%). Overall, the survey included 41% Allied Health Professionals respondents, 29% nurse respondents, 19% GP respondents and 11% pharmacist respondents. Survey respondents were primarily female (74%) with a minority of male (26%). In particular, nurse respondent (97%) and allied health professionals (77%) were primarily female. Survey respondents were fairly evenly distributed throughout the age groups 25-34 (22%), 35-44 (22%) and 45-54 (31%).

Table 9 provides a breakdown of the key demographic characteristics of the survey participants.

Table 9: Key demographic characteristics of survey participants

Variables	Overall	Pharmacists	GPs	Nurses	Allied Health professionals	Major cities	Regional/ remote areas
Total	n= 2921	n= 321 (11%)	n= 553 (19%)	n= 842 (29%)	n= 1206 (41%)	n= 2125 (73%)	n= 796 (27%)
Remoteness							
Major cities	2125 (73%)	238 (74%)	428 (77%)	532 (63%)	928 (77%)		
Regional to very remote areas	796 (27%)	82 (26%)	125 (23%)	311 (37%)	278 (23%)		
Gender							
Female	2173 (74%)	192 (60)%	240 (43%)	813 (97%)	928 (77%)	1550 (73)%	623 (78%)
Male	748 (26%)	128 (40%)	313 (57%)	29 (3%)	277 (23%)	575 (27%)	172 (22%)
Age group							
19–24	133 (5%)	18 (6%)		4 (0%)	111 (9%)	84 (4%)	49 (6%)
25–34	649 (22%)	132 (41%)	85 (15%)	59 (7%)	373 (31%)	501 (23%)	147 (18%)
35–44	656 (22%)	62 (19%)	159 (29%)	186 (22%)	249 (21%)	485 (23%)	171 (22%)
45–54	894 (31%)	65 (20%)	159 (29%)	374 (44%)	296 (24%)	632 (30%)	262 (33%)
55–64	512 (17%)	32 (10%)	119 (22%)	207 (25%)	154 (13%)	367 (17%)	145 (18%)
65+	77 (3%)	11 (4%)	30 (5%)	14 (2%)	22 (2%)	56 (3%)	22 (3%)
Primary professional qualification							
1: Pharmacist[15]	321 (11%)	321 (100%)				238 (11%)	82 (10%)
2: GP	553 (19%)		553 (100%)			428 (20%)	125 (16%)
3: Nurse[16]	842 (29%)			842 (100%)		532 (25%)	311 (39%)
4: Allied Health Professional[17]	1206(41%)				1206 (100%)	928 (44%)	278 (35%)

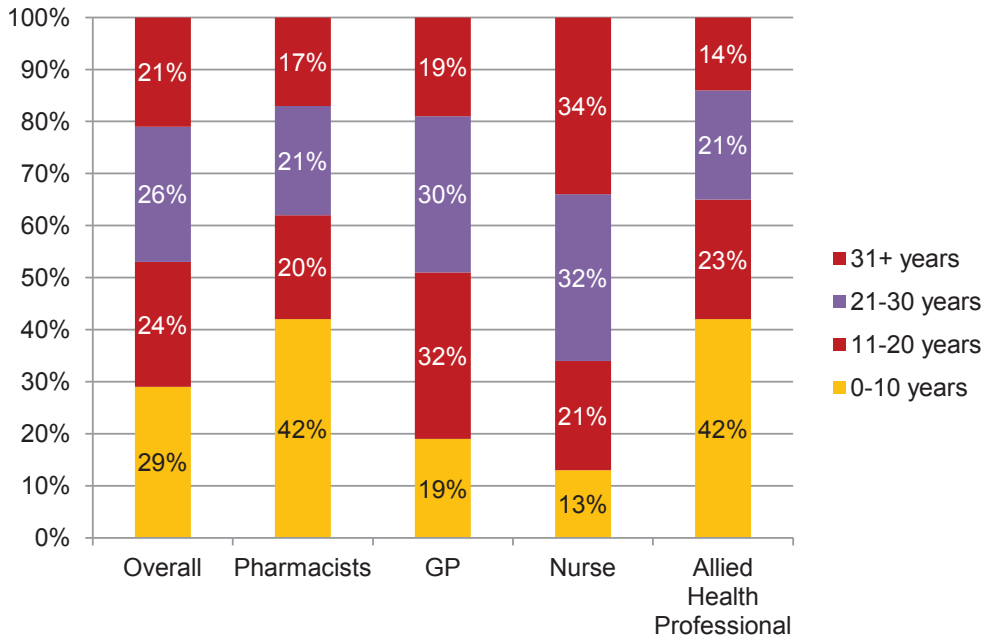
[15] Pharmacists (select all that options that apply included: 49% Community Pharmacists, 32% Proprietor of the 31% Consultant/Accredited Pharmacists, 26% Pharmacy Managers, 8% Independent Consultant Pharmacists and 5% other

16 Nurse respondents (select all that options that apply) included: 50%Registered Nurses, 49% Practice Nurses, 8% Nurse Professionals, 7% Enrolled Nurses, 6% Midwives, 4% Disease State Educators and 15% other,

[17] Allied Health respondents included: 37% Physiotherapists, 32% Dieticians/Nutritionists, 15% Occupational Therapists, 6% Dentists, 3% Podiatrist and 3% Social Workers and 4% other.

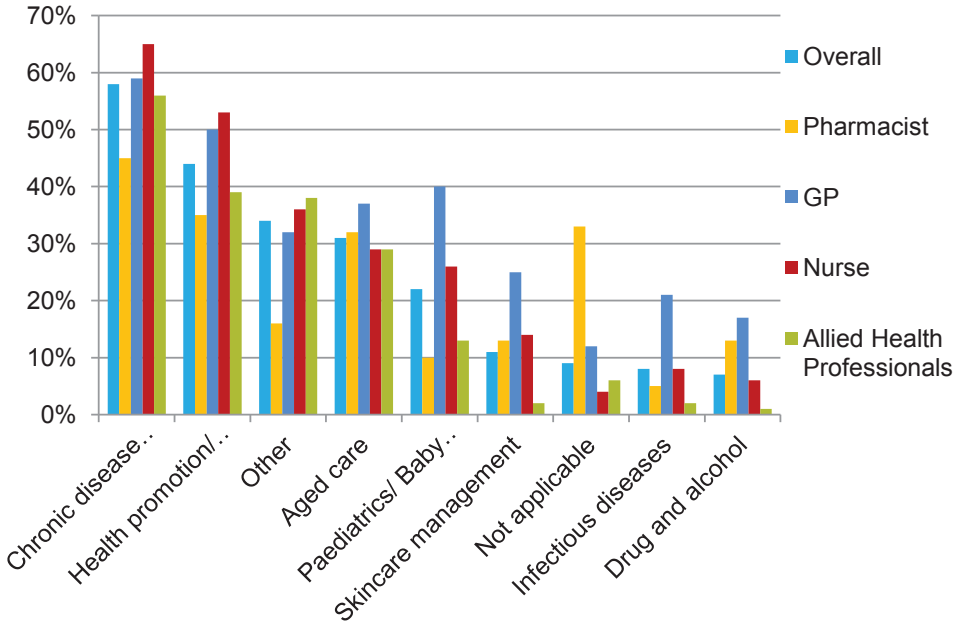
Survey respondents were asked to specify the number of years they had spent practising in primary health care. The results, as illustrated in Figure 10, indicate a fairly even distribution across the four categories for all respondents

Figure 10: Years practising in primary health care



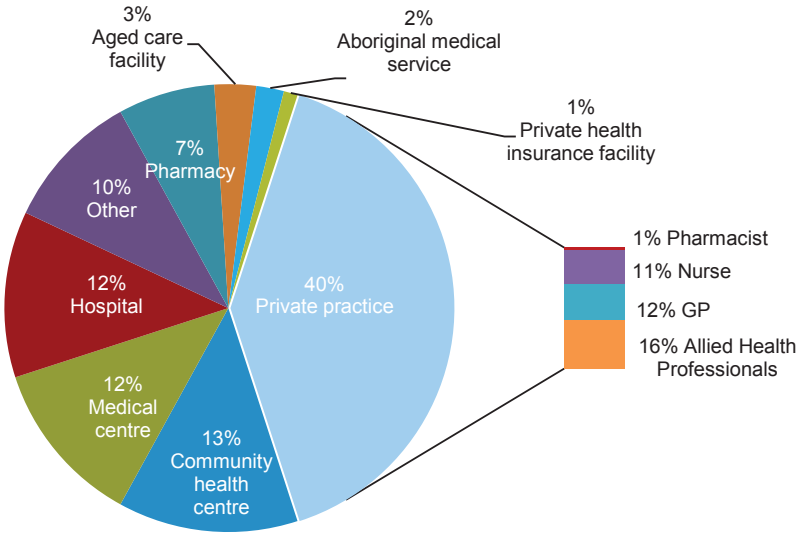
Survey respondents were asked to select all areas of specialisation applicable. As demonstrated in Figure 11, the most common areas of specialisation across all respondents were chronic disease management (58%) and health promotion and prevention (44%). In the "Other" category (34%), the most common responses were specialisation in general practise and medication (including information, safety and reviews). The least common areas of specialisation were drug and alcohol (7%), infectious diseases (8%) and skincare management (11%).

Figure 11: Area of specialisation



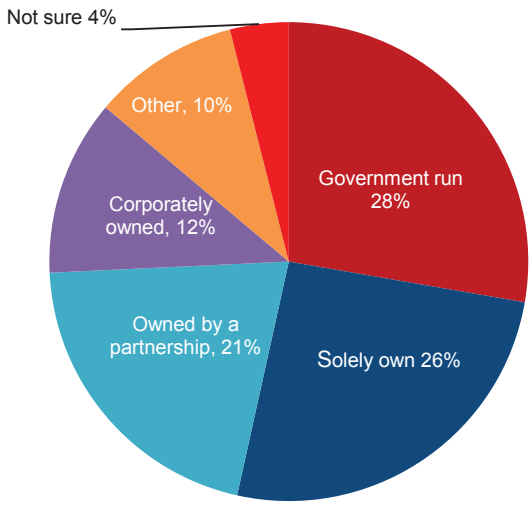
Survey respondents were asked to select the most applicable option for workplace where they spend the majority of their time. Half of all respondents indicated they worked in a private practice (50%). With respondents fairly evenly spread between the community health centre (13%), medical centre (12%), hospital (12%), other (10%) and pharmacy (7%) categories. Figure 12 depicts the split between the various workplace types and the breakdown of professionals who selected private practice.[18]

Figure 12: Main workplace



Survey respondents were asked to select the type of ownership of their main workplace. As illustrated in Figure 13, a majority of which were fairly evenly distributed across government run, solely owned and partnership owned organisations as indicated by the minority included a split between corporately owned and other organisations and not sure responses.[19]

Figure 13: Ownership of main workplace

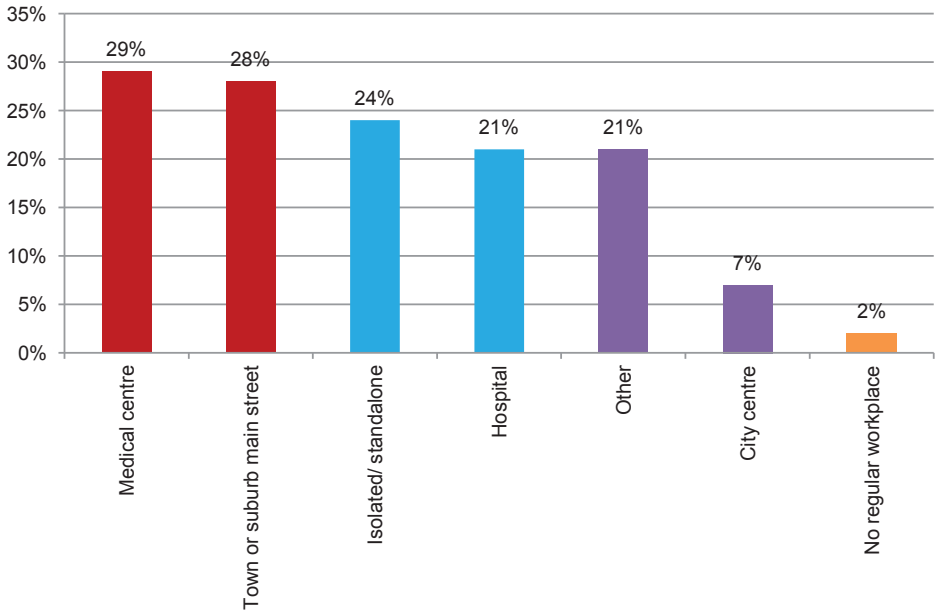


[18] While pharmacy is a form of private practice, it is assumed pharmacy would be selected as opposed to private practice in this instance.

[19] It must be noted that only 10% of pharmacists completed this question and therefore, the overall results presented below cannot be generalised to represent the pharmacist sample.

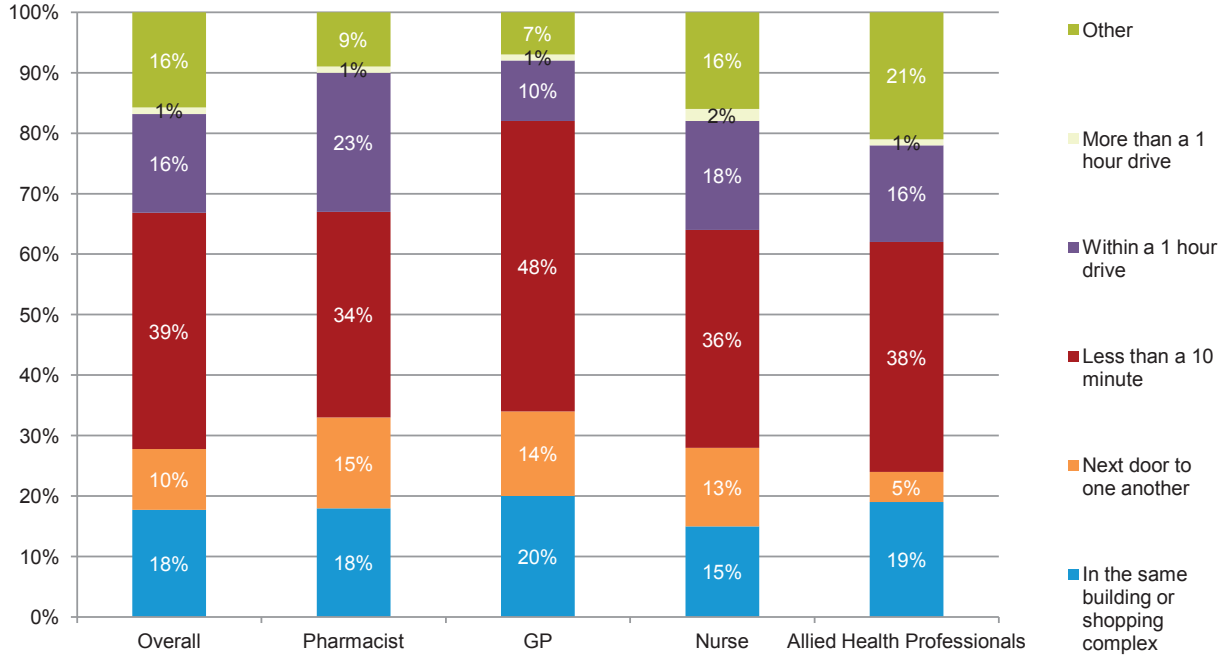
Survey respondents were asked to select the relevant options (select all which apply) which best described their main workplace. As illustrated in Figure 14, the location of workplaces was fairly evenly distributed across the majority of categories i.e. medical centre, town or suburb main street, isolated/standalone, hospital and other. The most common response in the "Other" category was working from home or in consumers' homes.

Figure 14: Location of main workplace



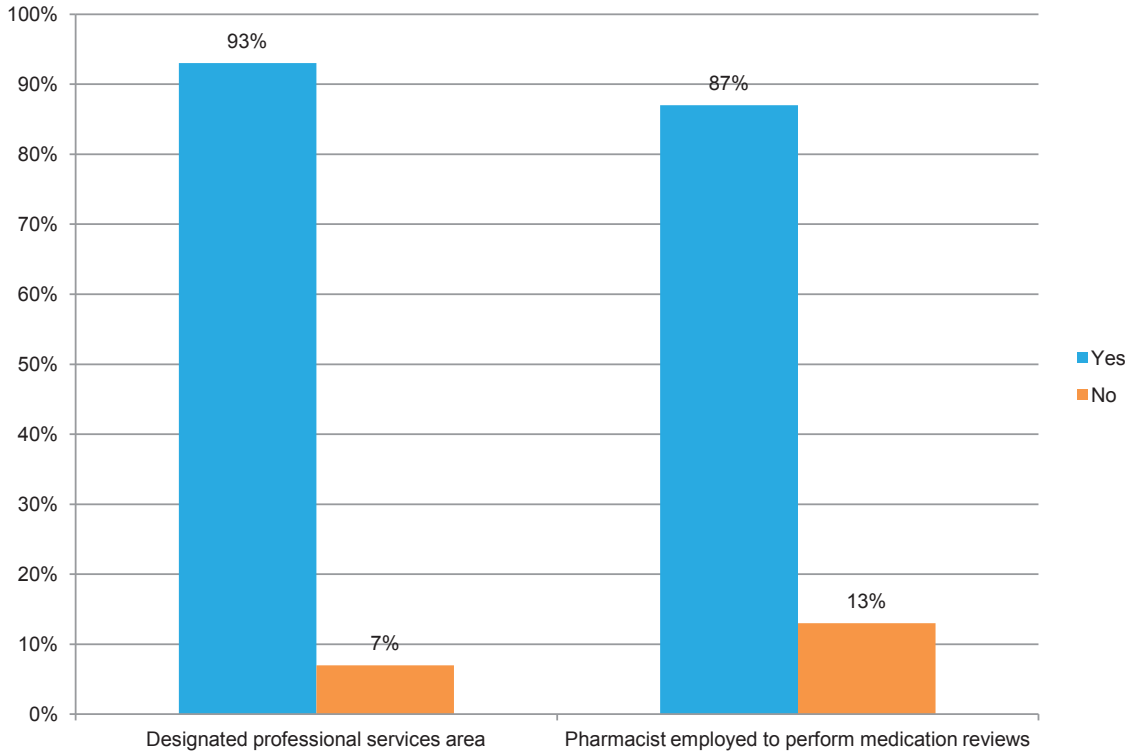
Survey respondents were asked to indicate the location of the community pharmacist or health care professional they collaborated with most often in relation to their workplace. As illustrated in Figure 15, two-third (67%) of all respondents reported that the health care professional they collaborated with most often was within a 10 minute walk of their workplace i.e., less than a 10 minute walk, next door or in the same building.

Figure 15: Location of most commonly collaborative health care professional



Nearly all pharmacists (93%) indicated the pharmacy they worked in had a designated area for professional services. In addition, a large majority of pharmacist respondents indicated that their workplace employs/contracts an accredited pharmacist to perform medication reviews as illustrated in Figure 16. This is indicative of a shift away from a community pharmacy 'shopfront' where the main activity is dispensing medications towards a health service provider where consumers can access health care services e.g. medication reviews

Figure 16: Workplaces with area for professional services/ pharmacists for medication reviews



6.3.4 *Frequency of collaboration and mode of communication*

Survey respondents were asked about the **frequency** of which they collaborate with different professions e.g. daily, weekly, fortnightly, monthly, every six months, yearly, never and not sure. It appears survey respondents most commonly collaborated with nurses (56%) and GPs (49%) on a daily basis. Conversely, survey respondents appeared to collaborate with pharmacists the least on a daily basis (15%).

For most professions, collaboration appeared to occur more frequently on a daily basis (38-56%) than on a weekly basis (16-30%) – with pharmacists being the exception to this case. These results are outlined in Table 10. Of note, 14% of survey participants had never collaborated with pharmacists previously.

Table 10: Frequency of daily collaboration across four professional groups

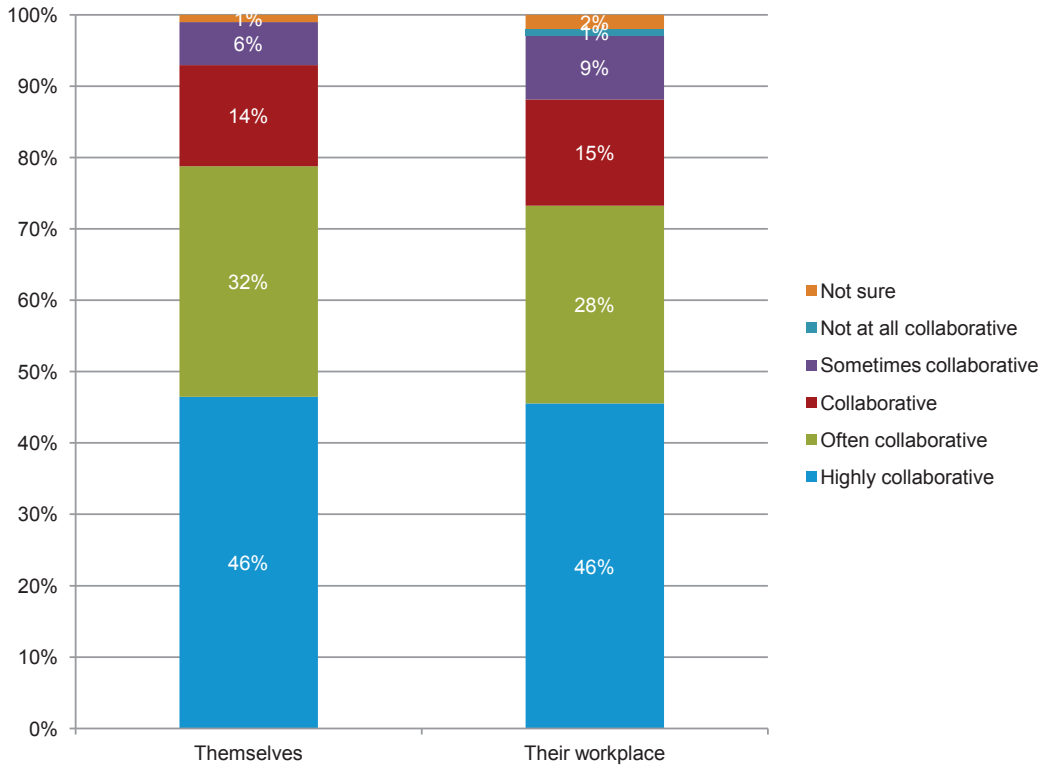
Professions	Frequency of daily collaboration	Frequency of weekly collaboration	Frequency of monthly collaboration	Frequency of monthly+ collaboration	No collaboration
Nurses	56%	16%	5%	5%	6%
GPs	49%	23%	6%	7%	6%
Allied Health professionals	38%	30%	9%	5%	2%
Pharmacists	15%	25%	11%	9%	14%

Further analysis of the frequency of collaboration indicated that there appeared to be no significant relationship found between the self-reported frequency of collaboration and the overall "collaborativeness" score, i.e. those who reported collaborating more frequently were **not** necessary more collaborative.

In addition, it was found that health professionals working in regional or remote areas tend to collaborate more often than those working in major cities, supporting anecdotal evidence from the stakeholder consultations.

The survey also asked respondents to rank **how collaborative they perceived** a) their workplace and b) themselves to be e.g. highly collaborative, often collaborative, collaborative, sometimes collaborative, not at all collaborative and not sure. As illustrated in Figure 17, findings across all professions, workplace types (e.g. private practice, medical centre, community health centre, hospital, pharmacy) and locations (i.e. major cities, regional to very remote areas) were fairly consistent. More specifically, participants perceived themselves (72 -83%) and their workplace (66-79%) as highly or often collaborative.

Figure 17: Perception of self and workplace collaborativeness



Further analysis of this indicated a lack of a significant relationship between respondents who perceived themselves or their workplace as more collaborative and overall "collaborativeness" score i.e. those who reported themselves or their workplace as highly or often collaborative were not necessarily more collaborative.

The survey also asked health professionals to select all their preferred mode of communication (e.g. mail, email, phone, videoconference, fax, face to face or prefer not to contact) in regards to contacting or being contacted by other health professionals (see Table 11).

Overwhelmingly, pharmacists preferred to contact other professionals by phone and similarly, other health professionals i.e. GPs, nurses and allied health professionals also preferred to contact pharmacists by phone. It would also appear that other health professionals preferred to contact pharmacists in person (45%) more so than pharmacists preferred to contact other health professionals in person (24%).

Table 11: Preference for contacting other health professionals

Profession	By phone	By fax	By email	In person
Pharmacist	89%	28%	26%	24%
Other health professionals	83%	27%	38%	45%

In addition, pharmacists also preferred to be contacted by phone by other health professionals and other health professionals preferred to be contacted by pharmacists by phone (see Table 12).

Table 12: Preference for being contacted by other health professionals

Profession	By phone	By fax	By email	In person
Pharmacist	92%	29%	40%	26%
Other health professionals	83%	27%	49%	36%

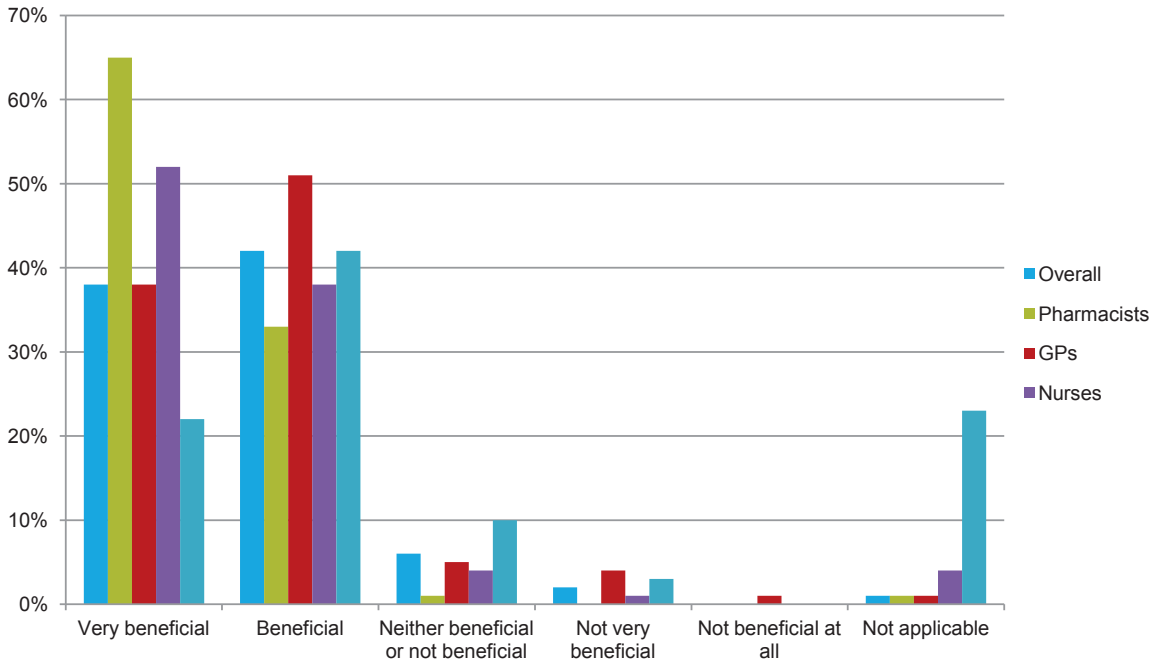
A thematic analysis of qualitative responses to an open ended question exploring survey respondents' experience of collaboration found that:

- Undertaking medicines reviews with other health professionals was a common form of professional collaboration
- Communication was vital however, GPs are often time poor and hard to reach for discussion
- Professional collaboration was greatly enhanced where there was an existing relationship

6.3.5 Benefits, enablers and barriers to collaboration

Survey respondents were asked about how **beneficial** they felt the experience of working collaboratively with other health professionals was (e.g. very beneficial, beneficial, neither beneficial or not beneficial, not very beneficial, not beneficial at all or not applicable) – as outlined in Figure 18. Nearly all pharmacists (98%) perceived professional collaboration as either very beneficial or beneficial. Meanwhile, GPs and nurses answered this question more favourably than Allied Health professionals.

Figure 18: Percentage of professional groups who perceive professional collaboration as either beneficial or very beneficial



Survey respondents were also asked to rank their top three benefits of collaboration, for the following three categories:

1 Consumer benefits e.g. improved quality of care; fewer clinic visits; enhance consumer safety

2 Professional benefits e.g. greater collaborative decision making; reduced workload; increased job satisfaction

3 Organisational and health system benefits e.g. decreased costs associated with hospitalisation; greater continuity and coordination of care; reduced service duplication

Findings across professional groups were fairly consistent in terms of which of the specific benefits of the three categories were seen as most important. Table 13 presents the most commonly cited benefits in the three categories.

Table 13: Perceived benefits of professional collaboration

Benefits category	Benefits	Perception of benefits by professional groups
Consumer Benefits	Improvement in quality of care	77%–92%
Professional Benefits	Greater collaborative decision-making	70%–89%
	Increased job satisfaction	47–76%
Organisational/ health system Benefits	Greater continuity and coordination of care	65–75%

Specifically, the different consumer, professional and organisational benefit options in the survey are shown in Figure 19, Figure 20 and Figure 21.

Figure 19: Consumer benefits of collaboration

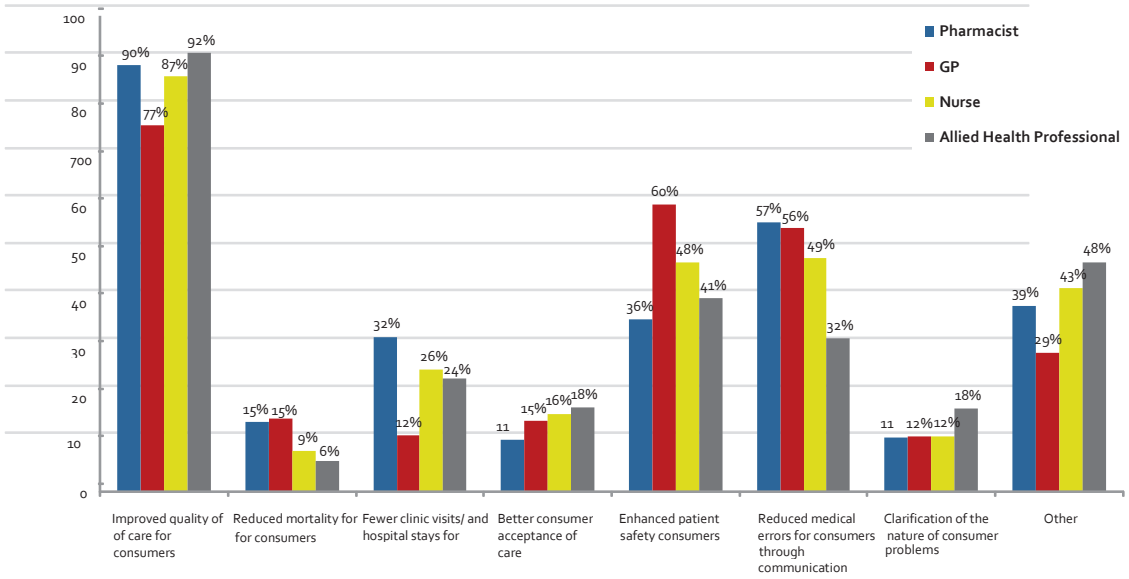


Figure 20: Professional benefits of professional collaboration

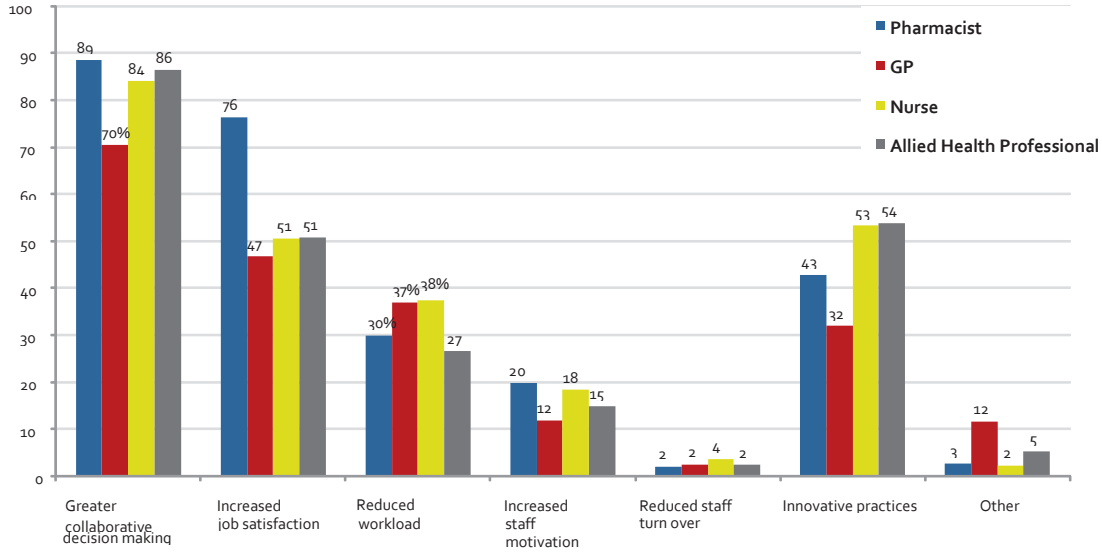
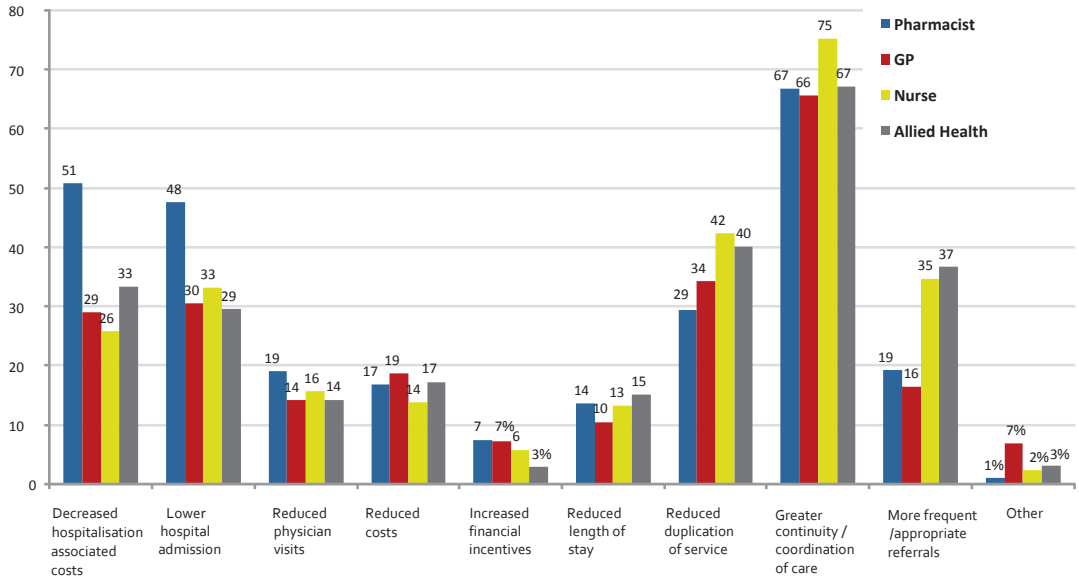


Figure 21: Organisational benefits of professional collaboration



In addition, respondents were asked to rank the categories of benefits in terms of importance, nearly all (89%) respondents cited consumer benefits as being the most important benefit of professional collaboration.

A thematic analysis of qualitative responses to an open ended question exploring survey respondents' perceived benefits of professional collaboration found that:

- Professional collaboration ultimately benefits the consumer's health outcome e.g. reduced hospitalisation
- As an additional benefit, professional collaboration can help to raise awareness of what different professions' areas of expertise are and their practice methods.

Consistent with findings from the stakeholder consultations and literature review, survey respondents also identified national level enablers and barriers to professional collaboration (e.g. legislation and policies; organisational structures and mechanisms; leadership; funding; location and infrastructure; technology; communication; building relationships). Respondents were asked to rank the most important enablers and most important barriers from 1 to 3. Communication (61-75%) and building relationships (54-57%) were cited as the most important enablers to professional collaboration by respondents. The main barrier to professional collaboration was reported as organisational structures and mechanisms (41-56%).

A thematic analysis of qualitative responses to an open ended question exploring survey respondents' methods of overcoming barriers to professional collaboration found the following to be important:

- Building a relationship and rapport with the health care professional
- Open and regular contact and taking time and effort to follow up
- Further training and education in collaborative behaviours
- Incentives for making collaborative practices worthwhile would enable professional collaboration
- Technological advances should enable timely communication

6.3.6 Attitudes towards collaboration

Thirty-one questions were used to assess participants' attitudes and behaviours towards collaboration using a six-point likert scale (i.e. strongly disagree; disagree; neither agree nor disagree; agree; strongly agree or not applicable) and an overall 'collaborativeness score', using principal component analysis was then calculated and used to identify characteristics that significantly impact attitudes and behaviours towards collaboration.

The mean score of each individual question by profession is represented below in Figure 22. Numbers closer to the centre of the radial plots indicate a lower level of "collaborativeness", while numbers closer to the outer ring indicate a higher level of "collaborativeness".

When looking at attitudes and behaviours towards collaboration, GPs (red line) appear to be closer to the centre and consistently displayed less collaborative attitudes and behaviour, while nurses (yellow line), followed by pharmacists (blue line), who consistently showed more collaborative attitudes and behaviour and are further away from the centre. Allied Health professionals (grey line) remain somewhat in the middle

Analysis of the survey respondents' demographic data showed that specific factors were found to have a significant relationship with attitudes and behaviours towards collaboration and respondents' overall "collaborativeness" score. In particular, the following was found:

- **Profession:** Nurses as a profession were the most collaborative, followed by pharmacists. GPs were the least collaborative profession.
- **Remoteness:** Participants working in rural and remote areas were more willing to collaborate than those working in major cities. This was consistent with findings from the stakeholder consultation, where collaboration happens more frequently in remote and regional areas because it is necessary and where health professionals know each other personally.
- **Age:** Participants aged between 35 and 44 and those over the age 65 were more willing to collaborate. This is an important finding in relation to the training and education specific age groups may have received. Similarly it suggests a relationship between experience as a health professional and collaborative behaviour, highlighting the importance of on the job mentoring and role modelling of collaborative behaviours by senior health professionals.
- **Type of workplace:** Participants working in a community health centre were most willing to collaborate compared to those working in private practices or medical centres. Findings from the stakeholder consultations also pointed to collaboration in medical centres being easier to achieve as health professionals were co-located and could communicate and meet up easily.
- **Specialisation:** Those specialised in aged care or chronic disease management appeared to be most willing to collaborate.
- **State:** Those from the Northern Territory and Queensland appear to be most willing to collaborate compared to those from Western Australia who were least willing to collaborate.

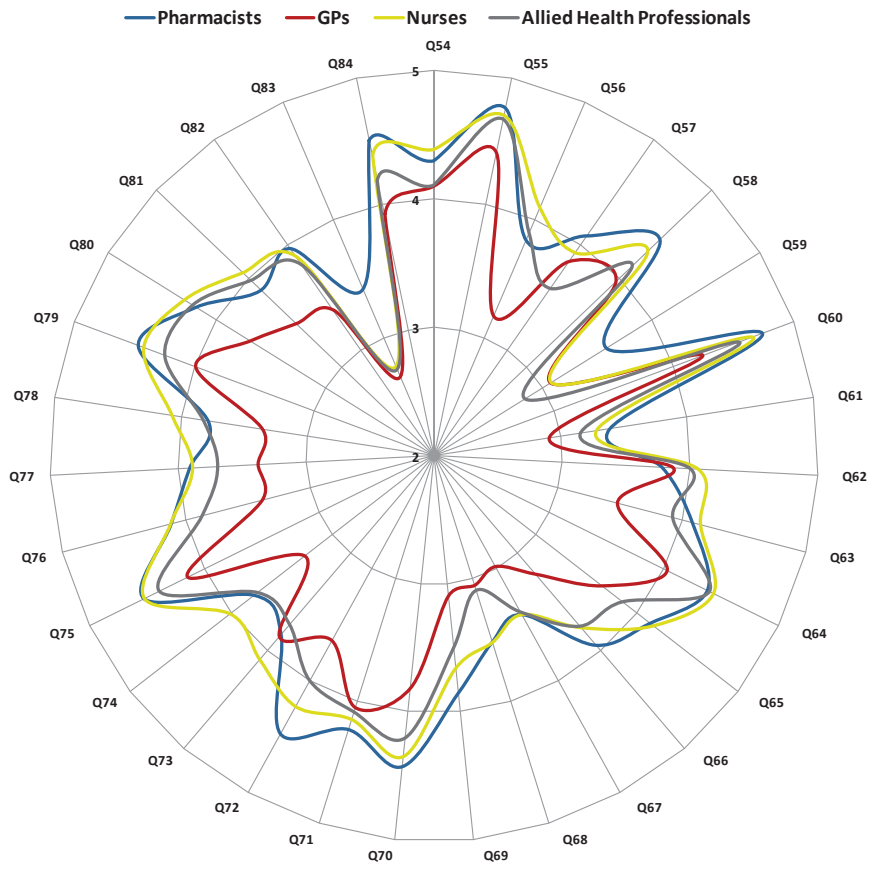


Figure 22: Attitudes and behaviours towards collaboration

Q54: Confident I will be able to collaborate successfully with other health professionals in the future

Q55: Willing to work with other health professionals

Q56: Collaborating is time-consuming and will disrupt the way I do things around here

Q57: Do not understand the roles and responsibilities of other health professionals

Q58: Willing to share consumer information with other health professionals

Q59: Received sufficient training in ways of working with other health professionals

Q60: Working collaboratively can better meet consumer needs

Q61: Our organisation provides resources to support collaboration

Q62: I am intimidated by all the new skills I have to learn to work collaboratively

Q63: The time could be better spent working on something else

Q64: Worried I will lose some of my professional status

Q65: Working collaboratively makes/ will make my job easier

Q66: Technology makes it easy for me to share consumer information and collaborate

Q67: Current higher education e.g. TAFE and university equips me with the skills to work collaboratively

Q68: My organisation has done a great job in facilitating working collaboratively in the past

Q69: Champions and leaders in my organisation serve as a role model and encourage working collaborative

Q70: I think my organisation will benefit from collaborating

Q71: I have the skills required to collaborate effectively

Q72: Working collaboratively with other health professionals is clearly needed change in the future

Q73: I feel other health professionals are willing to work with me

Q74: The effort required to collaborate with community pharmacists/other health professionals is small compared to the benefits coming from it

Q75: I respect and value the contribution of other health professionals

Q76: I would benefit from continuing professional development in the area of collaboration

Q77: The organisation's senior management is committed to working collaboratively

Q78: I do not anticipate any problems adjusting to new ways of working collaboratively in the future

Q79: There are legitimate and rational reasons to work collaboratively in delivering care

Q80: I do not trust the professional judgment of community other health professionals and hesitate to take their advice onboard

Q81: Any time spent on collaborating with other health professionals will be wasted given that legislation and policies don't support this

Q82: Collaborating with other health professionals matches the priorities or my organisation

Q83: Working collaboratively with other health professionals will have financial benefits for myself

Q84: I want to work collaboratively with community other health professionals

There also appeared to be differences between professional groups (although non-significant) in a further analysis of the questions about attitudes and behaviour towards collaboration. Some of these findings include:

- **Time consuming:** More GPs (16%) than other health professionals (3-5%) strongly agreed or agreed that the time spent collaborating could be better spent working on something else. In addition, more GPs (31%) than other health professionals (7-15%) felt that collaboration was time consuming and would disrupt the existing ways of working.
- **Professional status:** More GPs (8%) than other health professional (0%-2%) strongly agreed or agreed that collaborating would mean losing some professional status.
- **Financial benefits:** More pharmacists (51%) than other health professionals (23-25%) strongly agreed or agreed that working collaboratively would have financial benefits.
- **Trust and respect:** More GPs (14%) than other health professionals (2-5%) strongly agreed or agreed they do not trust the professional judgement of other health professionals and would hesitate to take their advice onboard. This result is indicative that GPs may have a higher professional bias. However, further analysis would be required to understand the basis of this attitudinal difference.
- **Value:** More GPs (8%) than other health professionals (2-3%) strongly disagreed or disagreed to respecting and valuing the contributions of other health professionals. This result is again indicative that GPs have a higher professional bias than the other health professions surveyed, however further analysis would be required to understand the basis of this attitudinal difference.

Collectively, there were a number of findings about health professionals' overall attitudes and behaviours towards collaboration. Of interest were the following:

- **Consumer benefits**: 94% of all respondents felt that collaboration could help to better meet consumer needs. This is complimentary with previous findings from the survey where 89% of respondents cited consumer benefits as being the most important type of benefit of professional collaboration.
- **Other benefits:** 74% of all respondents felt that working collaboratively would make their job easier and 86% felt that their organisation would benefit from working collaboratively.
- **Case for change:** 92% of all respondents felt there were legitimate and rational reasons to work collaboratively with other health professionals and 78% felt that working collaboratively was a clearly needed change for the future.
- **Willingness to collaborate:** 96% of all respondents felt willing to work with other health professionals and 73% felt that other health professionals were willing to work with them.
- **Readiness to collaborate:** 83% of all respondents felt they would be able to collaborate successfully in the future and 72% did not anticipate any problems adjusting to new ways of working collaboratively in the future.
- **Sharing consumer information:** 83% of all respondents cited they were willing to share consumer information with other health professionals

However, there are obvious areas where further development and effort could be directed towards improving levels of "collaborativeness". Some of these findings included:

- **Further training:** 38% of all respondents did feel they are sufficiently trained to working collaboratively with other health professionals and only 42% felt that current higher education equips them with the skills to work collaboratively
- **Continuing professional development:** 74% of all respondents felt they would benefit from continuing professional development in the area of working collaboratively
- **Roles and responsibilities:** 15% of all respondents felt they did not understand the roles or responsibilities of other health professionals
- **Support from leadership and management:** 51% of all respondents felt that leadership and senior management was encouraging collaborative practices and only 60% felt that their organisation's senior management is committed to working collaboratively
- **Further resources:** 40% of all respondents felt their organisation had done a good job of facilitating professional collaboration in the past and only 42% felt their organisation provided adequate resources for supporting collaboration

6.4 Summary of key findings and implications for a model of collaboration

6.4.1 Key findings

From the Primary Health Care Professionals Survey, a number of key findings were identified for informing the development of a model of professional collaboration. These include:

1 Participation and engagement

The way in which professions accessed the survey and responded was, in itself an interesting finding, in that GPs had the lowest response rates across the professions despite a guaranteed financial incentive. As found by Templeton et al (1997) the lower response rate from GPs does not reflect the validity of the data i.e. there has been found to be little evidence of a non-responder bias. However, it may reflect the context that GPs exist in, which includes a high administrative burden and little time for discretionary investment of time. While this has implications for future research, it also has potential implications to professional collaboration as this could also be considered discretionary investment of time for time poor clinicians.

This is supported by the GP responses to the question regarding collaboration being time-consuming and disruptive to their existing ways of working to which 31% of GPs (more than any other professional group at 7-15%) responded positively. In addition to this, more GPs (16%) than other health professionals (3-5%) strongly agreed or agreed that the time spent collaborating could be better spent working on something else.

2 Frequency of and attitudes to collaboration

Across all professions, most health care professionals viewed themselves (72% to 83%) and their workplace (66% to 79%) as being often or highly collaborative. However, there was no significant relationship between a higher self-reported rate of collaboration and an overall willingness to collaborate. It was found that health professionals working in regional or remote areas tend to collaborate more often and have more positive attitudes to collaboration than those working in major cities.

Nurses were identified as most frequently collaborating on a daily basis and to have the best attitude and willingness to collaborate. Pharmacists reported the lowest rates of daily collaboration, but were the second highest in willingness to collaborate. GPs were shown to be less willing to collaborate than other health care professionals – this may be related to how they want to use their time or to their attitudes towards other health professionals.

The significant relationship between age and willingness to collaborate emphasised the importance of facilitating professional collaboration at the beginning of a health professional's career – through interdisciplinary education at the university level and continuing after through regular interdisciplinary training.

3 Perceived benefits of collaboration

Although the majority of health professionals perceived collaboration to be beneficial, not all health professionals did; this implies that there are still health professionals who need to be convinced of the benefits of collaboration. In addition, nearly all (89%) respondents cited **consumer benefits** as the most important type of benefit over **professional benefits** and **organisational/health system** benefits.

74% of all respondents felt that working collaboratively would make their job easier and 86% felt that their organisation would benefit from working collaboratively. Almost all (94%) of the respondents felt that collaboration could help to better meet consumer needs. The majority of health professionals viewed professional collaboration to be beneficial or very beneficial (64%-98%) to meet consumer benefits. For example; improvement in the quality of care was consistently seen as the most important benefit (77%-92%). This has important impacts on communicating the case for change in any change program.

4 Inter-professional attitudes and beliefs

The most significant finding regarding interprofessional attitudes and beliefs was in relation to GPs' views of other primary health care professionals. A total of 14% of GPs (in comparison to 2–5% of other health professionals) strongly agreed or agreed that they do not trust the professional judgement of other health professionals. A further 8% of GPs strongly

disagreed with the statement that they respect and value the contributions of other health professionals; this compared to 2–3% for other professional groups surveyed.

5 Enablers and barriers

Organisational structures and mechanisms were reported to be the main barrier to professional collaboration. This finding supports the perceived disconnection between national, regional and local level practice. In order for collaboration to occur, the majority of respondents identified the need for further training and support from leadership and senior management. Other opportunities to enable collaboration included communication and building relationships across all professional groups. This supports the findings of the consultations and the literature review and mapping report.

6.4.2 Translating findings into practice

Based on the findings of the survey, the following were recommended to inform the development of the model of professional collaboration:

- Identify a **clear definition of what constitutes collaboration and alignment across professions**. The survey results show that health professionals may require further understanding of what collaborative practice requires and how this is different to just communication.
- Use the **survey results as a baseline understanding of current attitudes for collaboration** in planning implementation of the model, as this understanding assists in determining the overall readiness to act collaboratively at the health professional level and what behavioural and cognitive shifts need to occur before this can be successful.
- **Use lessons learned by professionals who work in regional and remote areas**. The survey data supports the previous findings that collaborative models of care delivery have been successfully formed in regional and remote areas.
- Emphasise that the model of professional collaboration is **consumer-centred** as primary health professionals share this vision which can provide the grounds for decision-making.
- **Identify a mechanism and incentives for GPs to participate in collaboration**. Their attitude to working with other health professionals is a clear barrier to collaboration. However, from the experience of the survey, financial incentives in return for their time commitment does not necessarily work for GPs.
- Encourage collaboration and collaborative practices through **support from leadership and senior management**. Similarly, collaboration will be encouraged by interdisciplinary training on how to collaborate and on understanding the roles and responsibilities of other health professionals.
- **Work at the local level** to provide structures and contexts to enhance interprofessional and intraprofessional communications and relationship building. Survey responses indicate that health professionals are **highly focused and motivated by their local context** and are less motivated by the wider policy context.

Professional Collaboration Design Forum

This section provides an overview of the process undertaken to facilitate the Professional Collaboration Design Forum, the learnings from this process and the outcomes of the forum. This section also identifies what findings from the forum were taken forward to inform the proposed models.

6.5 Purpose

The purpose of the *Professional Collaboration Design Forum* [20] was to begin to develop, with 61 key stakeholders, a practical and sustainable model of professional collaboration for health professionals in the primary health care setting to improve the health outcomes of consumers. This was achieved through: creating a broader level of understanding of the issue at hand; building consensus and alignment on the aim and value proposition of such a model; addressing likely risks to the model's implementation and proposing mitigation strategies; and developing an implementation roadmap to enable change with the relevant stakeholders.

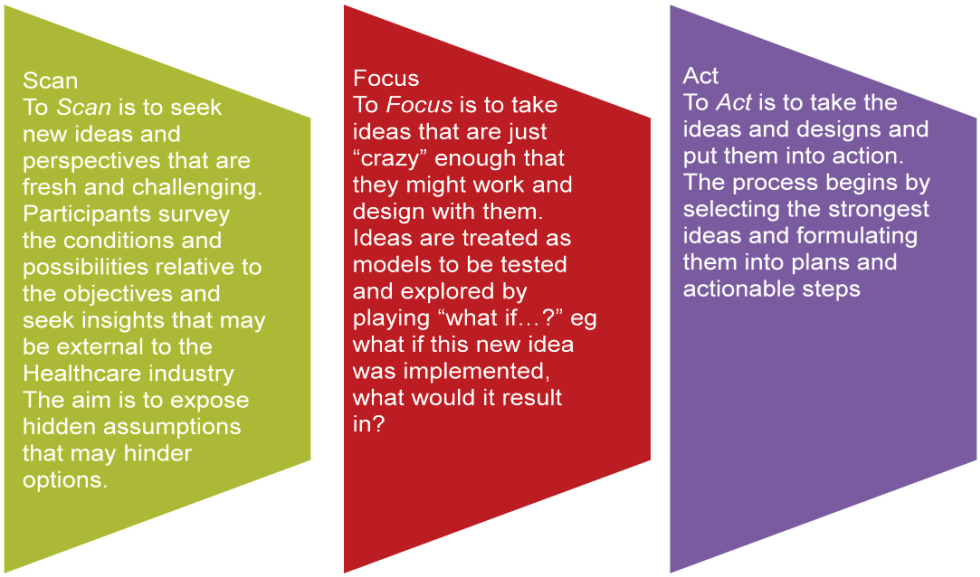
6.6 Approach

6.6.1 Design Forum methodology

The *Professional Collaboration Design Forum* was run by '*the Difference*', a business unit of PwC, over two-and-a-half days. *the Difference* specialises in scoping, designing and delivering design interventions that propose innovative solutions to complex, often transformational, issues.

the Difference has developed an approach to solution design as a product of over 30 years' experience in working with multiple organisations and draws on learnings from many diverse disciplines such as: business; education; architecture; psychology; and technology. *the Difference* uses multiple modes of facilitation including: graphic; environment; enquiry; task-based learning; experiential discovery; music; scenarios; and expert group facilitation and an accelerated, results-driven process to enable groups to align around complex solutions. As illustrated in Figure 23, the Design Forum methodology involves three stages: scan, focus and act.

Figure 23: Three-stage methodology used for the Design Forum



[20] Held on 7-9 August 2012

The benefit of taking the Design Forum approach to developing a model of collaboration was that it provided an environment in which primary health professionals and stakeholders could interact, share, collaborate and find points of alignment in relation to how the delivery of primary health care could be more collaborative and to develop an actionable change roadmap in a 2.5 day timeframe.

The process itself was a mechanism for significant stakeholder engagement and included those stakeholders who will ultimately implement the change. These stakeholders played a key role in designing of the outputs from the Design Forum.

6.6.2 Stakeholder engagement

Key to the success of any Design Forum is the high calibre of participants involved. If the solution reached in the Design Forum is to be viable, the participants needed to bring a broad range of insights and views from across the primary health care sector.

In order to target stakeholders that would be most relevant to this work, the Project Team mapped all primary health care stakeholders against the following criteria:

- Perceived influence on change
- Perceived extent to which each organisation/their members would be impacted by change
- Those that had expressed previous support/interest in participating in the Design Forum (gained from the stakeholder consultation)
- Specific outliers – those that bring a unique point of view or represent a minority group e.g. nurse professionals; Aboriginal and Torres Strait Islander Health; rural and remote; state government

This rationale acted as a guide to selecting invitees. Similarly, individuals that were invited to represent an organisation or professional group needed to be of high enough influence within their organisation to appropriately represent the views of that organisation and to be an advocate for the outputs of the Design Forum. For this reason, other than health professionals, CEOs and presidents of organisations were targeted to attend the Design Forum.

Once a list of key stakeholders had been agreed with the Advisory Panel, a communications strategy and plan for the Design Forum was developed. This allowed for consistent and positive messaging to be delivered to stakeholders regarding their attendance at the forum.

Overall, 104 participants were invited to attend with 61 participants accepting this invitation. Consumer and carer representatives, non-government organisations, pharmacists, GPs, nurses, Allied Health professionals, peak bodies, government representatives and academics from primary health care were present. Participants included representatives of those professions and organisations as listed in Table24.

Table24: List of professions and organisations represented by Design Forum participants

Aged and Community Services Australia	Diabetes Australia	NSW Agency for Clinical Innovation
Arthritis Australia	Eastern Sydney Medicare Local	NSW Institute of Psychiatry
Australian Association of Consultant Pharmacy	Efficient Dispensary Designs	NSW Ministry of Health
Australian College of Midwives	Emerald Medical Centre	Optometrists Association Australia
Australian Diabetes Educators Association	Health Workforce Australia	Palliative Care Australia
Australian Government Department of Health and Ageing	Illuminate Health Consulting	Pharmacy Guild of Australia
Australian Medical Association	Indigenous Communities Alliance	Pharmaceutical Society of Australia

Australian Medicare Local Alliance (AMLA)	Inner East Melbourne Medicare Local	PwC
Australian National Preventive Health Agency	Monash University	Royal Australian College of General Professionals
Australian Nursing Federation	Murrumbidgee Medicare Local	Society of Hospital Pharmacists of Australia
Australian Practice Nurses Association	National Aboriginal Community Controlled Health Organisation	University of Sydney
Cape York Guardian Pharmacy	National Prescribing Service	University of Technology Sydney
Carers NSW	National Rural Health Alliance	Western Sydney Local Health District
CLS Pharmacy Group	National e-Health Transition Authority	
Consumers' Health Forum of Australia		

6.6.3 Sponsor Team

The design of the 2.5 day Design Forum was developed by a Sponsor Team that included a representative sample of key stakeholders from across primary health care. The way in which the Sponsor Team was designed was to reflect the different points of view that were to be present at the Design Forum.

The Sponsor Team worked together with the Project Team over a period of eight weeks to co-design the event with the facilitation team from the Difference. This included articulating the purpose, objectives and givens of the Design Forum as outlined in Figure 25 well as identifying the specific issues and key questions which the Design Forum needed to address. They also played a key role in identifying the invitees for the Design Forum and modelling the behaviour and rules of engagement during the Design Forum.

The Sponsor Team included representatives from:

- The Pharmacy Guild of Australia
- The Australian Medical Association
- The Consumers Health Forum of Australia
- A community pharmacist representative
- A nursing representative

Figure 25: Design Forum purpose, objectives and givens

Purpose:

To improve health outcomes for all Australians by identifying a best practice model for primary health professionals to work collaboratively together.

Objectives:

1. Create a shared understanding of the health system
2. Understand how professionals are currently working
3. Explore current examples of collaboration
4. Design a practical and sustainable model that will improve outcomes for consumers including standards, principles and governance
5. Identify risks, barriers and enablers to inform the implementation requirements

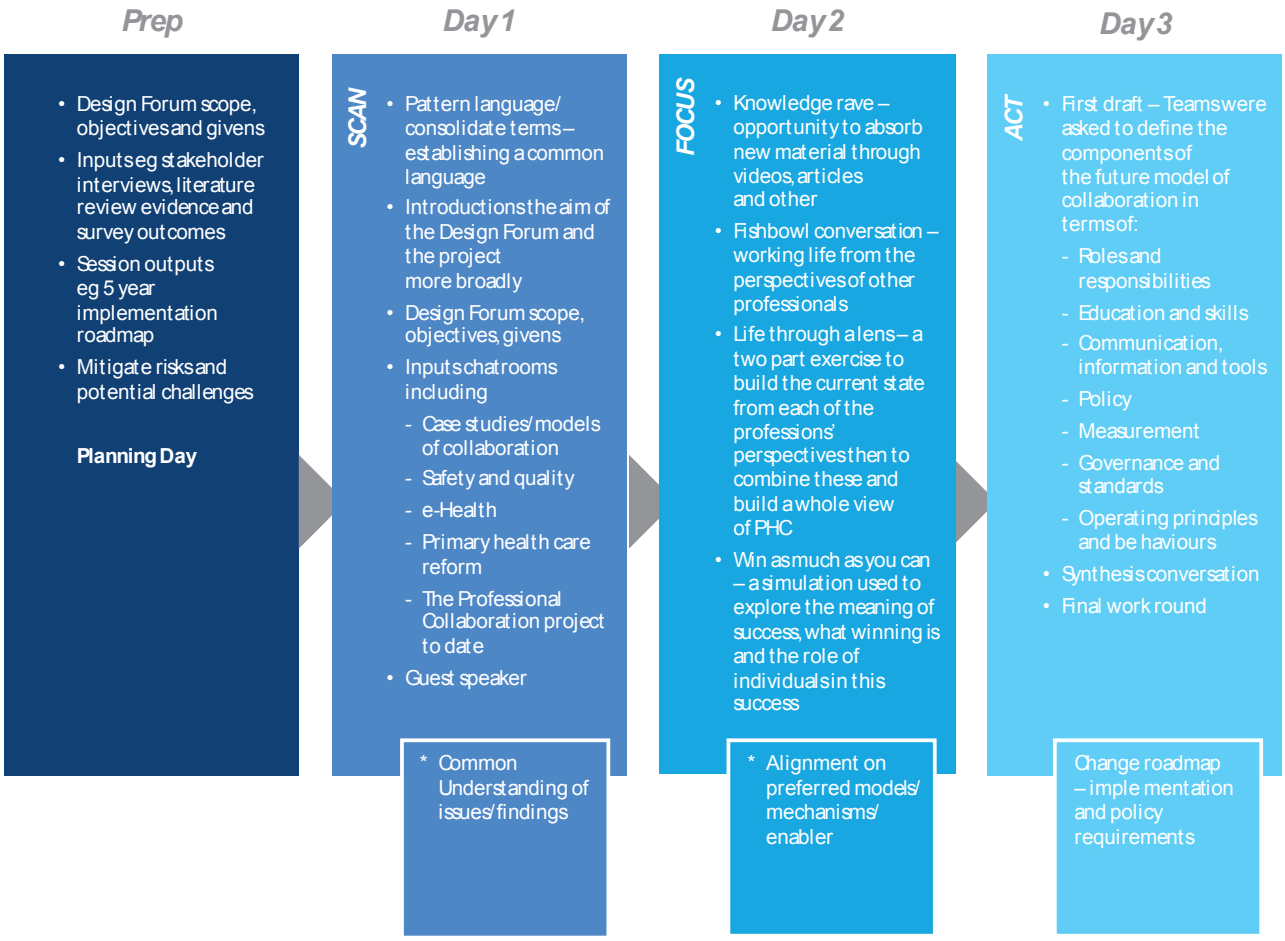
Givens:

1. The consumer is at the heart of what we are creating.
2. Shared knowledge across the primary health care sector, that includes providers and consumers, will provide better health outcomes.
3. An effective multi-disciplinary team will provide better health outcomes.
4. The use of IT may assist when consulting with the consumer, but it will never replace the need for personal interaction.
5. The roles of primary health professionals must be based on their scope of practice, areas of expertise and duty of care.
6. Any model identified must be: (1) feasible within the current health context and current health policy framework; and (2) applicable across different care settings, geographies and population demographics.
7. What we design must be financially sustainable for better health outcomes.
8. We acknowledge there are significant collaboration issues between primary health care and hospital care

6.6.4 Design Forum program

Each of the activities in the Design Forum program formed part of the overall journey that participants went on to explore what professional collaboration means in the current Australian context, to understand the perspectives of other primary health professionals and stakeholder and to work collaboratively to begin to design the elements of a future model of collaboration. A summary of the overall Design Forum program is presented in Figure 26.

Figure 26: The Professional Collaboration Design Forum program



Some key highlights of the Design Forum program included:

- **Guest speaker address** by Susan D'Ath Weston, Head of Safety at Qantas – Susan presented to the group on the safety and risk processes at Qantas and how Qantas has improved air safety through collaborative work practices and authority gradients.
- **Knowledge raves** – participants looked at stimulus materials, articles, and videos related to collaboration from outside of health care and discussed what learnings could be taken from these other environments.
- **Fishbowl conversations** – gave participants the opportunity to share experiences and insights on the current state of primary health care. This helped to create a better understanding of each other's professions and to hear first hand examples of what is and is not currently working in regards to collaboration.
- **Life through a lens** – participants stepped into the shoes of another primary health care professional and identified their specific challenges
- **Systems modelling** – groups modelled various aspects of care delivery

- **Scenario testing** – groups tested their models against real-life primary health care scenarios
- **Synthesis conversations** – held on day three provided participants with the opportunity to have an open and honest conversation about what was stopping them from achieving the objectives of the Design Forum.

6.7 Outputs of the Design Forum

The *Professional Collaboration Design Forum* culminated in the production of the key component parts of a model for professional collaboration. The key elements and characteristics of this model that gained general agreement across participants are summarised below and illustrated in Figure 27.

Policy and funding

- Peak body collaboration – formation of a "supergroup" to align on key issues and to clearly articulate the case for change to policy makers and funders.
- Inform policy top down and bottom up through strong vertical communication – leveraging pockets of excellence.
- Funding can be a barrier to collaboration between health professionals however it can also be an enabler therefore it is important to get it right.

Operating principles

- Every consultation is an opportunity to act collaboratively.
- Inter-professional trust, respect and evidence based practiced are a base requirement
- Pro-active follow-up of patients with other health professionals is part of quality care delivery cycle

Roles and responsibilities

- System based approach is required as we all have an impact on each other.
- Each of the actors in the system has a role and responsibility – Government, Peak Bodies, primary health care organisations (Medicare Locals), local providers and consumers.
- A Charter of Collaborative Practice is required

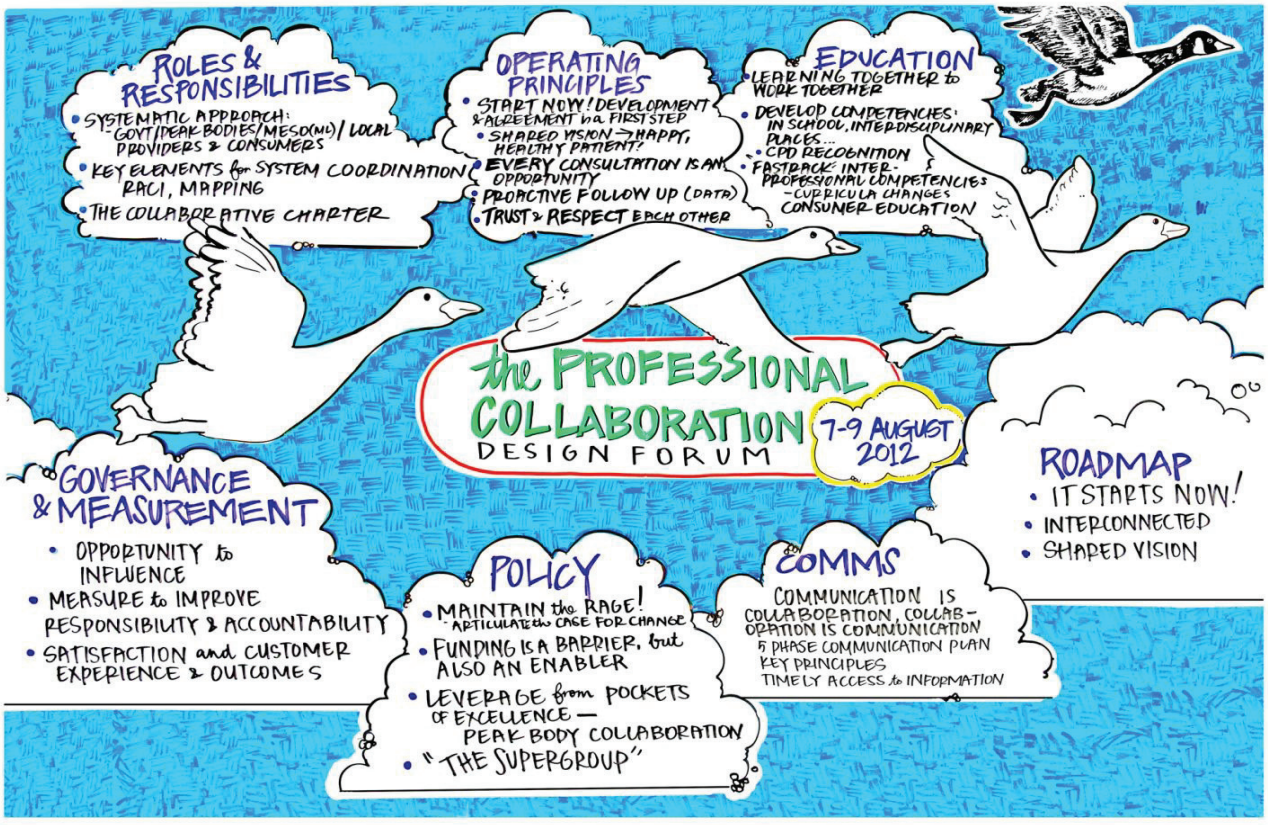
Governance, standards and measurement

- Peer review of collaborative practice
- Measurement is required to improve responsibility, performance and accountability for outcomes
- Consumer experience and outcomes matter

Education

- Different health professionals need to learn together to work together – interdisciplinary training and education on teaming would benefit primary health professionals.
- Collaboration competencies to be included in university and CPD curriculums
- Consumer education on collaborative health care and care coordination principles required to drive change.

Figure 27: Summary of the outcomes and recommendations from the Professional Collaboration Design Forum



The group identified the need for a charter for collaboration to which all health professionals would ideally subscribe and actively uphold under a new model of professional collaboration. It was noted by the group that while various professional charters of appropriate practice exist there is no single set of documented terms on which the multidisciplinary primary health care team agree to operate. At the culmination of the Design Forum this Collaborative Healthcare Charter, as seen in Figure 28 was signed by participants as a commitment to progressing the outcomes of the Design Forum within their own organisations.

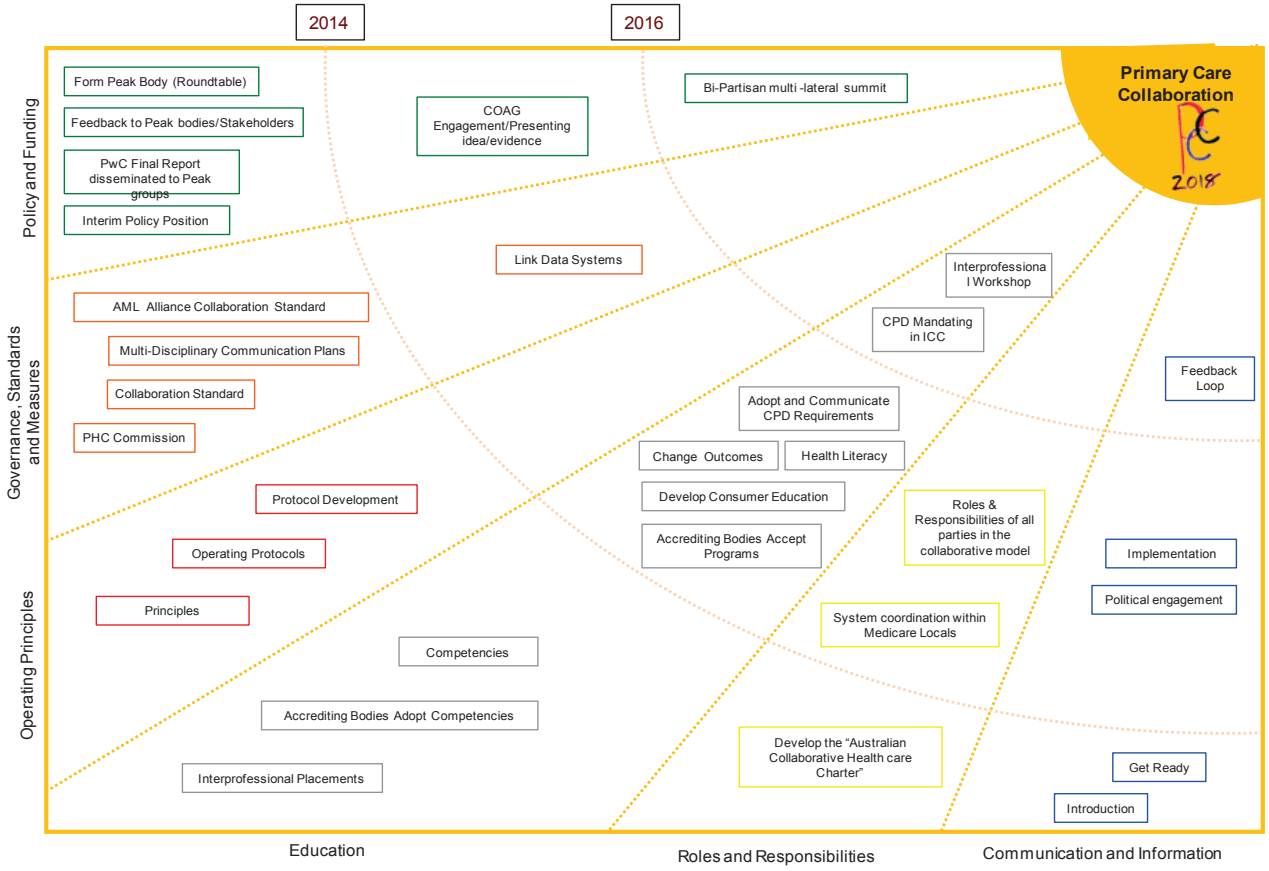
The Australian Collaborative Healthcare Charter describes a patient centric, needs based, equitable and accessible model of collaborative care for the Australian community – this includes:

- A commitment to collaboration as the model of health care for the future of all Australians
- A commitment to collaboration within health care from government peak bodies and health professionals, consumers and carers within the health care community
- A direction to Medicare Locals to develop a network of health care providers, pathways and protocols to ensure equitable access to an appropriate collaborative model dependent upon the health needs of the community/individual
- A strong and accountable governance model under the authority of the Medicare Locals to oversee implementation, development and delivery of services
- A mandate that the collaborative health care team through a system coordinator be required to provide system navigation and care coordination for those they service, including as they transition in and other parts of the health community and social systems
- A requirement that all members of interprofessional teams work within their scope of practice and commit to collaborate with other professionals within the collaborative health care team
- A commitment to the standards of the collaborative health care model as part of the quality assurance process.

Figure 28: The Australian Collaborative Healthcare Charter developed by the Professional Collaboration Design Forum

As an outcome of the Forum, the participant group also identified a Roadmap for the implementation of their model for professional collaboration. It was felt by the group that the model and its various education and policy components could be successfully implemented within five years. This roadmap is illustrated in Figure 29.

Figure 29: Roadmap to implementation



This roadmap for implementation formed the basis of the final model implementation considerations and projected timings. For example, the roadmap of implementation illustrates the establishment of a *National Primary Health Care Professional Forum* occurring in parallel with local initiatives.

6.8 Summary of key findings and implications for a model of collaboration

6.8.1 Key Findings

Key findings from the Design Forum that informed the proposed model of professional collaboration come from:

- The outputs produced by the forum
- The observations and insights gained in working with this group of primary health professionals

These will be explored further below.

Findings from outputs produced by the forum

Consistent with previous research (Keleher, 2012), the Design Forum identified that collaboration happens at three levels

- National/system level
- Regional/local level
- Practice level

Alignment was gained on some core elements of the future model including:

- Mechanisms to address policy and funding at the national level
- Core operating principles
- Clarification of roles and responsibilities
- Governance and measurement
- Standards of collaborative practice
- Education and training
- Communication

Observational findings:

Through the Design Forum it was observed that:

- Understanding and perception of the changing primary health care context varied by participant.
- Intergroup biases such as mistrust and a lack of understanding of roles exist and were highlighted by group discussions.
- Systems-thinking was a challenging concept to some participants who have not previously thought about their role in primary health care in this way.
- The case for professional collaboration, above and beyond what currently occurs in primary health care practice, was not well understood by some participants and acted as a barrier to reaching the full objectives of the Design Forum. This is an important finding for future similar activities in change management.
- This type of discussion was new for some participants and not for others. Approximately 70% of feedback received suggested that this was a new and exciting discussion. Close to 60% of participants reported feeling enthused to participate in professional collaboration initiatives between primary health care professionals

6.8.2 Translating findings into practice

Based on the findings from the Design Forum, the following key considerations specifically influenced the development of the model of collaboration:

- The Design Forum identified **several high-level protocols to be developed nationally or locally.**. These included :
  - Process for referrals to occur(Written/phone/electronic)
  - Clinical information flow – minimum data sets that should go with consumer (e.g. eHealth record or partial summary with referral)
  - Interprofessional code of conduct/behaviours, including respect between professionals, responses to referrals and feedback loops
  - Performance monitoring/governance
  - Communication – Hierarchy of escalation
  - Quality and safety mechanisms and improvement cycles
- The National Primary Health Care Professional Forum was an idea developed during the Design Forum as a mechanism for collaboration at the national level between peak bodies for professions, consumers and carers. The objectives of such a body were identified as:
  - Contribution to developing standards/protocols for membership of the collaborative model
  - Demonstrate to government the peak body willingness/preparedness to collaborate to produce policy change and redesign funding models
  - Formal agreement between peak bodies of the collaboration charter/standards
  - Broad strategy for upward (to government) and downward (to members) communication.
- There was **support for the role of new meso-level primary health care organisations (i.e. Medicare Locals) in driving at the regional/local level the objectives of the national forum** which include:
  - Liability frameworks – currently no clear way for responsibility to be shared among numerous providers
  - Funding models identified did not incentivise collaboration
  - Roles and responsibilities of professionals – Scope of practice ceilings/when to refer/who to refer to
  - Develop a standard of collaboration in line with the outcomes achieved by the Design Forum
- There was **support for the role of new meso-level primary health care organisations (i.e. Medicare Locals) in driving at the regional/local level the objectives of the national forum.** – this was identified to include:
  - Coordinate implementation at local level against population health needs
  - Educative role within the community including membership
  - Leading cultural change locally
  - Mapping /directory of professionals available, services available and existing care coordinators

7 Key findings and implications for the model

Findings across the five phases of the Professional Collaboration project were consolidated to inform the development of the model of professional collaboration. The findings of the project were highly complex, consistent across the various activities of the project and largely interdependent.

The key findings, their source activity and the way in which they informed the development of the model is summarised in Table 14.

Table 14: Key findings from the *Professional Collaboration* project and implications for the model

Finding[21]	Description of finding	Source[22]	Implications for the model of professional collaboration
K1: Policy and strategy*	A lack of a shared strategic vision for in primary health care was identified as a significant barrier to professional collaboration between professional groups at a national and regional level (e.g. Medicare Locals). Effective leadership and support for collaboration across organisations at these levels were identified as necessary enablers to change behaviours and attitudes throughout the system.	SC, LR, DF	For collaboration to be successful there needs to be a nationally led commitment which aligns to the current primary health care strategy and policies. This model proposes that a *National Primary Health Care Professional Forum* be established with multidisciplinary peak body representation to seed and propagate collaboration between health professions as well as guide this shared vision and expedite informed policy decisions. The model also requires policy to be informed by practice at the local level – that is, the *National Primary Health Care Professional Forum* should specifically aim to address the key issues collectively reported up by the local and regional levels.
K2: Funding*	The current fee-for-service funding model was often cited as a key barrier to collaboration. As it stands, GPs, specialists and pharmacists are reimbursed under the Medicare Benefits Scheme (MBS)and Pharmaceutical Benefits Scheme (PBS) and there is no financial incentive for them to participate in collaborative efforts outside of the time that the consumer is in front of them. For example, a GP who responds to a consumer's blood results and advises them on next steps via the phone before then speaking to their pharmacist and/or diabetes educator is not compensated for this time. A more appropriate incentive for collaboration needs to be identified to promote more collaborative behaviour.	SC, LR	Funding structures need to reflect the value of collaboration and time and effort spent in non-consumer facing activities. Funding also needs to be monitored and evaluated against appropriate performance standards. The *National Primary Health Care Professional Forum* provides the appropriate mechanism to reach agreement on these issues.

21 *Denotes elements that form the foundation of the proposed model

22 SC: Stakeholder Consultation; LR: Literature Review; PCS: Professional Collaboration PHC Professionals Survey; DF: Design Forum

Finding[21]	Description of finding	Source[22]	Implications for the model of professional collaboration
K3: Governance and standards*	Many of the health professional peak bodies operate within silos, with deeply entrenched views and no shared vision on collaboration. Likewise at a more individual level, not all health professionals shared the same understanding of the potential benefits of collaboration – either from a care delivery or a professional satisfaction perspective	SC, LR, DF	In addition to the role of the *National Primary Health Care Professional Forum*, the regional and local level clinical governance networks will need to define and implement governance frameworks which are needed to better support and promote professional collaboration and the standards by which health professionals will practice. These governance frameworks and standards need to be developed within an interdisciplinary environment.
K4: Measures*	Data on collaborative practice is rarely collected and there are currently no standardised set of measures against which to evaluate this. The National Health Performance Authority (NHPA) has recently released performance measures for primary health care that will provide a platform for further adaptation.	SC, DF	The model proposes that collaborative efforts must be evidence-based and measurable to build a case for change. Success needs to be defined by evaluating outcomes against a standardised set of measures. These measures need to be defined in an interdisciplinary environment, such as that of the *National Primary Health Care Professional Forum* or a delegated working group and aligned to standards set by the NHPA.
K5: Roles and responsibilities*	While there was a reported willingness to collaborate among health professionals, there is still a general lack of understanding and respect of other health professionals' roles and responsibilities (particularly among GPs) and how they would work together in a collaborative model. In some cases this can lead to some perverse negative attitudes and perceptions about fellow health professionals. Issues included (1) perceived lack of confidentiality regarding sharing consumer information; (2) perceived lack of training and qualification of some health professionals to suitably provide care; (3) perceived liability in "sharing" care delivery; (4) the perceived loss of status for GPs when collaborating and the (5) perception that the commercial agenda of pharmacists and Allied Health professionals are in conflict with delivering evidence-based care to consumers. Unsurprisingly, such issues were less apparent where collaboration is a necessity for effective health care delivery e.g. in remote areas, or where health professionals are located in close proximity e.g. in hospitals or medical centres. Likewise, collaboration was identified as being more challenging in metropolitan areas where	LR, SC, PCS, DF	The model seeks to increase the interdisciplinary interactions at both the local and national level to enhance understanding of each other's professional skills and as a point of priority, to define the roles and responsibilities of health professionals within a interdisciplinary team. Clear roles and responsibilities enable building of good working relationships between health professionals, particularly as accountability of different aspects of the care delivery is transparent and every health professional can practice at their 'full scope of practice',[23] and use every consultation as an opportunity to improve the consumer's health. This will allow the health workforce to be utilised more effectively.

23 "Full scope of practice" can also refer to the term "at the top of their license" in the context of this report. And refers to health professionals practising to the full extent to which their training and education has equipped them

Finding[21]	Description of finding	Source[22]	Implications for the model of professional collaboration
	there are multiple providers and less consistent patterns of provider usage.		
K6: Communication*	Timely and effective communication between all stakeholders is a necessary (but not sufficient) enabler for collaboration. Currently, however, communication is perceived to be generally ad hoc and slow among health professionals unless there is "something in it" for them. Lack of time was cited as the main barrier to effective communication.	LR, PCS	Information sharing was identified as a key enabler to collaboration and more specifically collaborative decision making. Regular communication can be supported, but not replaced, by new technology solutions such as eHealth records. The model proposes mechanisms to enhance communication at the national, regional and local levels; however, the concept of time as a barrier to communication raises further policy issues in regards to how this is incentivised in the current fee-for-service funding model.
K7: Education and training*	Education is delivered in silos and further support and training around collaborative practices was reported as being needed. Similarly, survey results identified that respondents aged between 35 and 44, and those over the age 65, were more willing to collaborate than other age groups. This is an important finding in relation to the training and education specific age groups may have received. Similarly, it suggests a relationship between experience as a health professional and collaborative behaviour, highlighting the importance of on the job mentoring and role modelling of collaborative behaviours by senior health professionals.	SC, PCS	Building relationships needs to start at the university level through interdisciplinary education which is complemented by joint training. Interdisciplinary continuing professional development activities could allow for these relationships to be built and nurtured post university. Mentoring and education is an important component of the model and as a driver of behavioural change across the system.
K8: Consumer	There was agreement among stakeholders and health professionals that collaboration is ultimately for the benefit of the consumer and that the consumer should be at the centre of care. There was also recognition that the needs of a consumer and the objectives of their care differ due to a number of factors, such as level of health/care required, health literacy and potential for self-management.	SC, PCS, DF	The consumer needs to be at centre of care and the optimal outcome of collaboration is to improve the consumers' health. The model proposes that services at a local level be structured in a way that supports this. The model also proposes a way of segmenting the consumer population in order to identify those that would most benefit from collaborative care in the first instance. This assessment should be done after analysing the appropriate data regarding service usage.

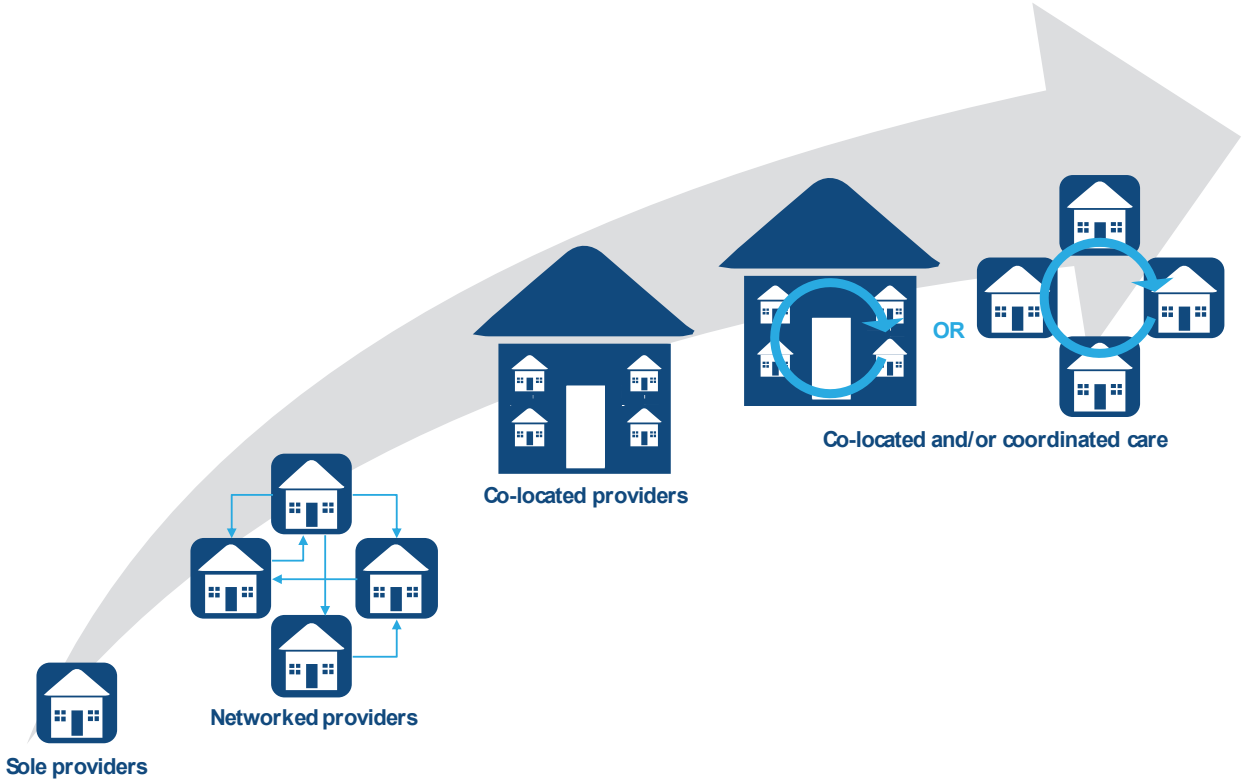
8 Model of professional collaboration

This section describes the proposed model of profession collaboration which is implemented at three levels, at the national-level as a new system model called the 'National Primary Health Care Professional Forum' and localised models that are enacted at the regional/local level. All levels of the model are interdependent on each other in achieving successful collaboration. Each part of the model has guiding principles, key elements and performance levers and these are presented along with challenges to their implementation.

8.1 The current context

In the Australian primary health care sector, the currently observed model of practice shows limited collaboration between health professionals. The providers of health care are networked providers, communicate as required and sometimes cooperate in relation to the care of a consumer. However, while health professionals may coordinate care with joint responsibility between them, they do so while retaining individual practitioner status when giving and receiving assistance from one another. At the same time, many health professionals work as sole providers of health services, sometimes in isolated practices. Overall, it is seen that occasions of what can be considered as collaborative practice usually do not occur in a systemic fashion, but as a result of personal relationships developed between individual health professionals.

Figure 30 Evolution of Australian primary health care system from sole providers towards integrated care models



Australia's current primary health care reforms are encouraging a shift from a central focus on health care providers delivering care in a series of transactions (i.e. consultations, operations) to a holistic model that focuses on the consumer. This model involves a health team that is integrated, where possible located in the same premises, and leverages the skills of different health professionals. But this practice is evolving and not yet widely accepted by all professions as illustrated by Figure 30. For example, while GP Super Clinics are intended to provide a good example of this approach, a recent evaluation of seven established GP Super Clinics suggest that more collaboration is necessary beyond service co-location and shared eHealth records (Cosidine et al., 2012). It was also found that a multidisciplinary approach has been lacking and delivery of care and services are still informed only by individual professional practices. While codes of conduct and protocols exist for individual professions, there are none covering multiple disciplines.

Both the findings from the GP Super Clinics evaluation and the *Professional Collaboration* project suggest this is a critical step in achieving the objectives of greater collaborative care.

8.2 About the model

The ultimate objective of the *Professional Collaboration* project was to develop a model for professional collaboration that is feasible within the current and future policy context and is actionable, implementable and aligned with the overall strategic aims of relevant stakeholders and primary health care reform more widely.

The previous activities of the *Professional Collaboration* project, and all relevant and applicable information collected throughout the project, have all informed the development of this model. This has included:

- Consultations with key stakeholders and domestic and international experts
- A literature review of enablers to and barriers of professional collaboration and a mapping exercise of existing models
- A survey of primary health professionals
- A Design Forum to gain alignment between stakeholders to design a practical and sustainable model.
- A further series of consultations with professional groups and individual health professionals regarding the draft model for collaboration. This consultation invited feedback from the following:

- Australian Government Department of Health and Ageing
- The Australian Medical Association
- The Australian National Preventive Health Agency
- Australian Nursing Federation
- NSW Agency of Clinical Innovation
- NSW Institute of Psychiatry
- NSW Ministry of Health
- Pharmacy Guild of Australia
- Royal Australian College of General Professionals
- The Society of Hospital Pharmacy in Australia
- Project partners:
- Graduate School of Pharmacy, University of Technology Sydney
- The Professional Collaboration Project Advisory Panel (including a diverse selection of stakeholders)
- Australian Medicare Local Alliance

The collective result of all of these activities is a model with three parts, a proposed national level collaborative network responsible for driving systemic level change and a regional/local level collaborative network responsible for facilitating collaborative care partnerships at the regional and local levels.

8.2.1 What is a system model?

In developing a model to better support professional collaboration, it is recommended that a 'systems-thinking approach' be used. This approach asks clinicians and administrators working at national, regional and local/practice levels to focus on the whole health care system rather than on individual parts. Recognising there is one Australian health care system and one healthcare budget creates an effective basis to define roles, prioritise funding and work together to improve the overall system. This systems-thinking approach has been utilised internationally by health systems that have successfully integrated care services (Gullery, 2013; Ham and Walsh, 2013).

A simple summary of the systems-thinking approach is that solving problems and analysis should be based on considering the whole of a system, and breaking down that system into parts to methodically consider how decisions or actions of these individual parts contribute to the success or failure of the whole system (von Bertalanffy, 1968). This approach also recognises that a system is not merely the sum of its parts, but also the interrelationships between its parts. When analysing a complex system such as primary health care, the individual parts are less important than their interactions and the level of collaboration that exists at the systemic level (Tsasis et al., 2013).

A 'system model' is a stylised simplification of a system and its components and how they relate, depend and interact with each other. The model shows complex interactions in a consistent and logical manner and how changes to variables or assumptions will impact on behaviour. The key components of a system model include:

- Actors: the key roles, people, systems and other entities in the model
- Relationships: the flow(s) of activity, information or other exchanges between actors

- Annotations: descriptions of the purpose, nature and other attributes of both actors and relationships to make them meaningful to other readers
- Frame: the boundary of the model that defines what sits within and outside the model (note that some actors may be referenced outside the frame, as they have direct relationships with actors inside the frame).

8.2.2 Guiding principles of the model

The development of a model of collaboration needs to recognise the current and future policy context, be actionable and sustainable, and needs to be aligned with the overall strategic aims of relevant stakeholders and primary health care reform more widely. In this way, the strategic vision of the system needs to be defined. As such the following key guiding principles were identified at the Design Forum.[24] These were:

- **All primary health professionals have a shared vision for *happy, healthy, health-literate consumers and carers* living in their community.**
- **A consumer/patient-centred model** in which the needs of the consumer, their experience in receiving appropriate care and driving better consumer outcomes are the main focus. Respect for consumer choice, access to quality care and proactive follow-up and feedback to consumers are key underlying features. The importance of having the consumer at the centre of care was emphasised heavily during stakeholder consultations. Consumer needs are a type of product or service which is required based on factors difficult or impossible to change e.g. prescribed medications. Needs are the desires which take the form of a "must" urgency in acquiring to achieve satisfaction and can be met or unmet (Raikin and Uyar, 1996).
- **Every consultation is an opportunity to improve a consumer's health and journey**. That is, every contact a consumer has with a primary health care professional should act as a doorway to an appropriate path of care or informed self-management. It is every primary health care professional's duty to provide evidence-based advice and appropriate referrals when they identify a potential situation for disease management or prevention.
- **All care and advice provided by primary health professionals needs to be based on evidence and best practice**. As primary health professionals, all advice provided to consumers must have an evidence base. The understanding that evidence and positive intent is the basis of the advice provided fosters a level of trust and teamwork between primary health professionals. Currently, stakeholders reported little data is being collected to measure collaborative practices.
- **All primary health care providers have a duty of care to their consumers**, as well as a duty to respect their colleagues to provide optimal outcomes for consumers within the use of the public funds available.
- **Leadership to be displayed by professional bodies in achieving collaboration between primary health professionals** at the national level and identifying strategic policy, funding and self-regulation solutions in a collaborative manner. A key competency here will be systems thinking. At peak body level, the importance of modelling collaborative behaviours and the existing inter and intra-professional biases was noted during the stakeholder consultations. This line of thinking was further expanded upon in the findings from the survey of on the ground health professionals who reported needed increased support and commitment from leadership in terms of collaboration in the future
- **Building trust and professional respect,** all professionals involved in this systems-based approach embrace the opportunity to better understand the skills and role of other primary health professionals within the system. In doing this, individuals and professional groups are required to build trust and respect for each other's contribution to the system as a whole. Key aspects of such an approach include:
  - **Adherence to good communications** practice and hierarchy
  - **Pro-active follow-up and feedback** to the identified primary health care professional team.

  The importance of building strong working relationships between health professionals working on the group was consistently reported through the stakeholder consultations where successful examples of collaboration often depended on a strong working relationship between professionals as well as any model including mechanisms for communication.

[24] The professional Collaboration **Design forum** was held in August 2012 with the aim to gain alignment between 61 stakeholders and to design a practical and sustainable model of professional collaboration between community pharmacists and other primary health professionals that will improve health outcomes for consumers.

Building strong relationships and effective communication were also enablers found during the literature review as well as the most important enablers cited by survey respondents.

- **Collaboration for optimal outcomes,** collaboration among peak bodies, consumers groups, providers, funders and policy makers to achieve optimal system-based outcomes. Outcome orientated collaboration i.e. collaboration to improve the consumers' health outcome were reported to be the most important benefit of collaboration. Stakeholders during the consultation cited that collaboration practise should be evidence based best practise and outcomes measurable.

8.2.3 Key elements and performance levers

In the Design Forum, participants identified the basis for seven key elements and performance levers required by a future model for Professional Collaboration. There is also notable consistency in the structural and process elements of existing models identified through the *Professional Collaboration Literature Review* including the Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative from Canada (2005).

Each element must be considered carefully in order for the model to be delivered in the current primary health care context and can be considered a fundamental building block. All elements must be considered together; the section below describes these in terms of **definitions** and prime **considerations**.

Policy and strategy

Primary health care policy and strategy is currently driven by the Australian Government who, in 2010, introduced Australia's first National Primary Health Care Strategy – *Building a 21st Century Primary Health Care System –to better integrate and* coordinate health services for the Australian population (Australian Government Department of Health and Ageing, 2008).

The proposed model must include policy mechanisms with which collaborative care teams at the local level can influence future policy and strategy at the regional and national level. In case of disagreement on policy issues, a national mechanism or interprofessional forum of primary health care professionals will be essential to resolve issues – and to encourage a shared vision of collaboration rather than fragmentation at the regional and local levels. .

Funding

The AIHW has published an estimate from 2004–05 that $35.5 billion was spent on primary health care services. Just under half of primary health care funding (47%) is provided by the Australian Government (Australian Government Department of Health and Ageing, 2009). The suggested model for professional collaboration does not propose a specific funding approach, but instead the right infrastructure and systems most likely to facilitate effective professional collaboration, irrespective of specific funding models. If these are in place, the model will remain relevant and useful in case of changes in policy or funding in primary health care

In fact, it is recognised that the proposed model will require investment by all stakeholders involved, in the form of time and relationship building. It will require organisations to make the enhancement of collaboration between primary health care professionals a strategic objective to which they will commit time and some general funds to its establishment, monitoring and evaluation. This does not preclude collaborative practices being funded directly in future where there is a clear business case.

Table 15 describes the funding models currently in operation in Australia and internationally (Appleby et al, 2012; Charlesworth et al, 2012):

Table 15: Funding models operating in Australia and internationally

Payment term/system	Description	Further description/examples
Block	Payment/lumpsum for a specific- usually broadly defined – service independent of number of consumers	Block funding examples in Australia include State government payments to hospitals and DoHA payments to State Governments and other health agencies.

Payment term/system	Description	Further description/examples
Capitation	Lump sum payment per consumer served by a provider for comprehensive services or particular categories of service regardless of treatment received.	The NHS currently fund the majority of GPs in this way. Payment is related to the number of consumers on their list (weighted by age and other characteristics). The activities they are expected to deliver for these consumers under these payements is defined broadly by the GP National Contract In a competitive market this payment model is strong in prevention of health issues in consumers and reducing costs however critics of this model argue that quality of care suffers. Kaiser Permanente and ACOs in the US are examples of capitation payments to a network of institutional providers however these have specific quality targets not present in most capitation models.
Pathway/episode of care	Single payment to cover an entire episode/pathway of care.	Pathway/episode payments may cover all the activities after initial identification of a problem or need from diagnostic investigation through to rehabilitation. In the Netherlands an initial evaluation of episode based payments for standard care of patients with a number of common chronic health issues found an improvement in coordination of care between providers and improved adherence to care protocols by patients (Nutfield Trust, 2012)
Case based	Activity-based reimbursement per patient based prospectively on diagnosis/patient characteristics.	Under activity –based funding acute hospitals in Australia will receive payments for case-mix classification according to Diagnostic Related Groups (DRGs) classification system.
Per Diem	Lump sum payment per patient per day of care regardless of consumption of care.	Many Private Health Care Insurers in Australia operate on Per Diem payments for hospital admissions. That is the hospital receives a payment per day in hospital however the price per day usually decreases to encourage discharge.
Fee for service	Activity-based (prospectively set)unit payment for a defined intervention regardless of patient characteristics.	GPs and specific allied health professionals in Australia receive fee for service payments for MBS items. For example a GP is paid per consultation with a consumer regardless of complexity. This is often also accompanied by a gap payment by consumers. The form of payment does not encourage any efficiency in care pathway and is weak in enhancing technical and allocative efficiency. This payment model increases activity is very weak in controlling overall health care costs as well as encouraging "transactional" provider behaviour.
Pay for performance	Payment is linked to achievement of specific performance targets.	Australian GPs currently receive extra payments for meeting practice accreditation standards that represent this payment model. The biggest pay for performance system in the world, the quality and outcomes framework was introduced in UK primary care in 2004. It is a voluntary scheme but almost all practices participate as they receive a substantial proportion of income through the scheme. Early evaluation suggests a positive impact on quality.
Bundled payments	A single payment covering multiple elements of a consumer's treatment	Bundled payments involve the aggregation of different care requirements that were previously paid for separately e.g. diagnostics, medication and treatment for specified condition. This model is considered to support collaboration across health professionals. In the Netherlands Bundled payments are being used to incentivise organisations to work more closely together

Payment term/system	Description	Further description/examples
		for three specific chronic conditions: Diabetes, Chronic Obstructive Pulmonary Disease (COPD) and vascular risk management.
Unbundled	Separate payments for disaggregated elements of a consumer's care	Unbundling relates to services that were previously covered by a single payment to one provider – but are potentially better delivered in collaboration with other providers and multiple payments.
Mixed or blended systems	A combination of different payment methods.	In practice payment systems may include some or all of these systems. For example Australian GPs are currently paid through multiple models listed.
Individual care budgets	Provides individual budgets to people with long-term conditions to cover non-medical support services such as therapy and nursing services, home care, day care and meal services, complementary therapies, mobility assistance, leisure services and equipment.	These have been piloted in the UK since 2009 This funding model forms the basis of the National Disability Insurance Scheme to be introduced in Australia in 2013.
Accountable Care Organisations	Ties provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients.	Traditional fee-for-service program who are assigned to it. (Centers for Medicare and Medicaid Services) This model is currently used in the US.

Governance and standards

A framework for governance is important to hold relevant stakeholders accountable while they carry out the objectives of a strategy. In primary health care, these objectives are safe and quality care delivery to improve consumer health outcomes. The model of professional collaboration proposes defining a sound governance framework that will drive and sustain behaviours, both individual and organisational, that lead to better collaboration, and hence, better consumer care. The goal of any governance framework is to drive behaviours, both individual and organisational, that lead to better consumer care. Governance frameworks are based on two approaches – that of minimum standards, and also of continuous improvement that aims for excellence in care (Queensland Health, 2012).

Measures

The success of the proposed model for collaboration needs to be defined by evaluating outcomes against a set of measures or performance indicators. Measuring the success of a system is often related to quantifying outputs. For this model, outcomes should be directly attributed to a behaviour or intervention. Doing this drives responsibility and accountability through the entire system and reinforces system-based thinking. For this reason, measures should always be collected at the level of and as consistent with outcomes reported in *Professional Collaboration Literature Review and Mapping Report (5th Commu*nity Pharmacy Agreement, 2012):

1. consumer outcomes – improved experience and/or health measures of patients/consumers (in context of all risk factors present)
2. provider outcomes – improved experience of providers and professional development outcomes
3. organisation/system outcomes – improved cost efficiency and effectiveness of the organisation/ system.

Roles and responsibilities

The proposed model needs to consider the roles and responsibilities of the different health professionals involved in collaborative efforts. An understanding of the roles and responsibilities particular to each health profession is necessary to analyse the access of a given population or community to health professionals and health services, and to explore where there is a better use of highly skilled professionals.

The roles of primary health care professionals are often formalised through registration legislation or scope of practice guidelines which inform the expected roles and responsibilities of current health care professionals and are generally developed by each profession themselves, often with little interaction with other related professions. In addition, there is a series of other legislative and financial constraints on each of the professions, at both the national and state and territory levels, which often reinforce or further restrict the role and responsibility of each profession (Australian Government Department of Health and Ageing, nd).

Communication

Communication is a key element in the proposed model. Without effective, regular and two-way communication, collaboration is not possible. Communication is defined as the transmission of data or information from one person to another and the receipt and consideration of this information. All communication should have a purpose; the degree to which this purpose has been satisfied determines the success or failure of the communication (United Nations Educational, Scientific and Cultural Organisation, n.d.).

A meta-analysis (Foy et al, 2010) identified communication as most effective when it is a two-way purposeful interaction whether face-to-face or telephone, joint video-conferencing involving the consumer, primary health professional and specialist.

Key aspects of communication that will impact the proposed models include information management and sharing, via verbal, electronic, paper-based or visual means in the following ways:

1 Interprofessional – between organisations/practitioners of different primary health care related professions

2 Intraprofessional – between organisations/practitioners of the same profession

3 Upwards – to inform policy

4 Downwards – to inform practice.

Education and training

Education and training is a necessary element of the proposed model; it will determine the way in which future health professionals perceive each other and work together. International experience suggests that collaborative models of care require new skills to be developed by health professionals and managers including working in teams across different settings; creating win-win solutions and approaches; exercising sensitivity; and removing silos (Agency for Integrated Care Singapore, 2012). International research suggests that undergraduate and graduate health professional education would benefit from curricula focused on team-based problem solving rather than autonomous decision making (National Patient Safety Foundation, 2012).

Change management principles suggest that individuals need to be educated and trained in the desired new processes and behaviour. It is also important that these processes and behaviours are then modelled by leadership in practice. Health Workforce Australia has previously looked at similar changes to curricula to include consistent training of health professionals in relation to cultural safety (Health Workforce Australia, 2011).

8.3 The Model

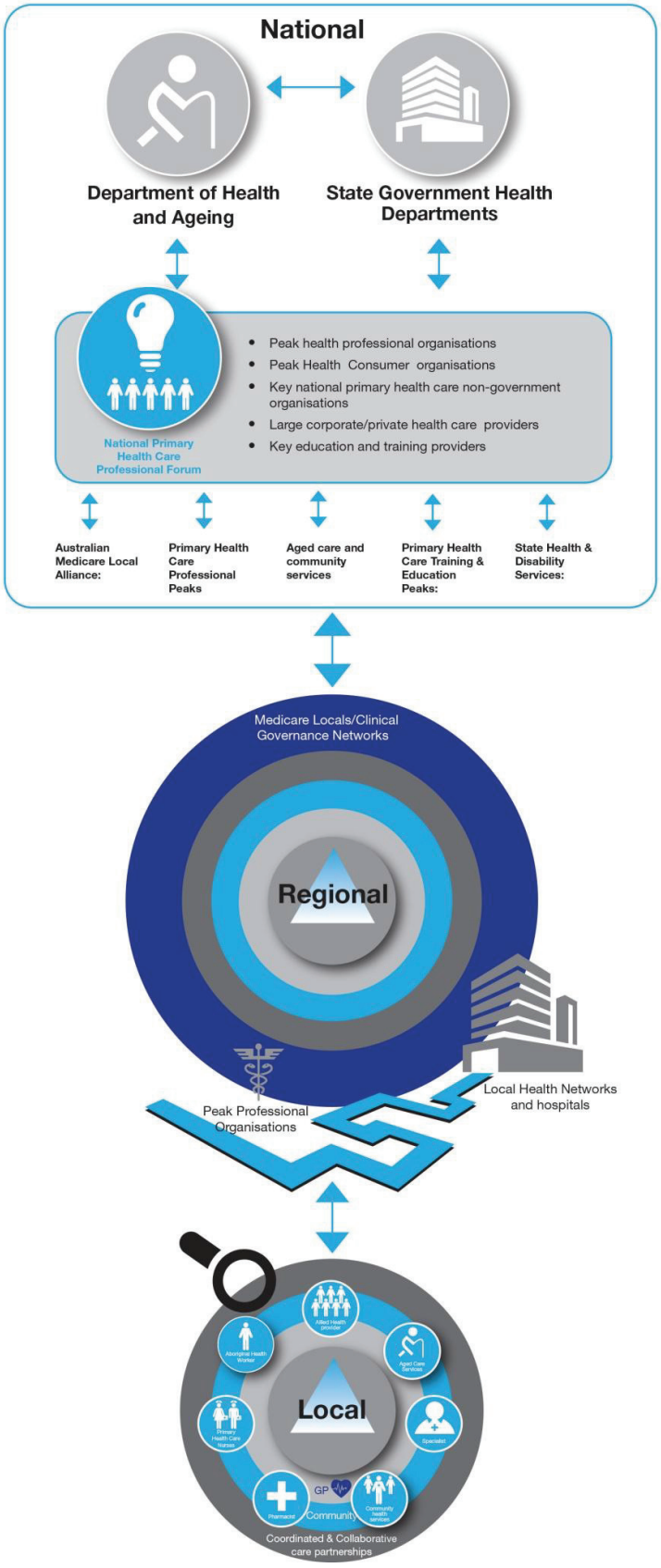
The model proposes:

- A three-tier model comprising national, regional and local levels (see Figure 31: Overview of the model of professional collaboration(. This is in line with international literature on integration occurring at the micro, meso and macro levels (Pim etal, 2013).

- The formation of a *National Primary Health Care Professional Forum* to provide overarching leadership and strategic vision for the role and function of each of the key players involved. In order to achieve collaborative care, identifying a common purpose between different professions and organisations, and shared arrangements for leadership and governance are key. The principles on which the Forum is based can then pass onto the regional level via Medicare Locals and then to the local practice levels of the model through a range of activities such as case conferencing (Ham and Walsh, 2013).
- A structure that encourages behavioural and attitudinal change, facilitated by a range of key underpinning principles.
- Engagement of front-line health professionals through transparent and real 'bottom-up' and 'top-down' communication. As such, throughout the implementation of the model, experiences as the local and regional level will help inform the national approach to collaboration. The Medicare Locals will play a key role in linking communication and initiatives from the local and national levels.

Importantly, the model leverages and builds on existing infrastructures (e.g. Medicare Locals) partnerships (e.g. Lead Clinicians Group) and models (e.g. the Home Medicines Review program (HMR) and multidisciplinary chronic disease programs) wherever possible and does not attempt to create further layers of complexity or bureaucracy.

Figure 31: Overview of the model of professional collaboration



8.4 A national-level model for professional collaboration

The key findings of the *Professional Collaboration* project to date suggest that the causes of the lack of collaboration are at systemic and national levels. The fragmentation and silos between primary health care providers are caused by policy, legislation, and fee for service funding structures as well as a lack of leadership and role modelling of collaborative behaviours by peak organisations and professional colleges.

In total, there are more than 25 peak bodies for primary health care professionals, each with professional allegiances and agendas, who lobby for policy and funding decisions. This makes it extremely difficult for policy makers to identify alignment and agreement of priorities in the Australian primary health care community. Findings of the *Professional Collaboration Primary Health Care Professionals Survey* suggest that only 60% of primary health care professionals feel that their organisation's management are committed to working collaboratively with other professions

International experience from Singapore, the United Kingdom, Canada and New Zealand suggests that political buy-in, leadership and partnership (in areas from policy development to implementation and evaluation) are absolutely necessary. This is supported by the change management principles proposed by Tsuyuki and Schindel (2008). In particular, they note that change of this magnitude cannot be driven by a single individual or organisation; any approach requires the efforts and commitment of the whole health care sector and at all levels. The national level needs to share a vision and provide a role model for the desired behaviour that can then be confidently implemented at the practice level.

While collaborative practices at the local and regional levels will be the key agent for improving collaboration, the national-level model provides the infrastructure and support to empower and sustain it, driving an agreed vision for collaboration, working towards excellence in collaboration, and for that to become a standard of practice. The national –level model is illustrated in Figure 32.

Overview of the national model

At the national level, the goals of the model are to form a national collaborative partnership between health professions in order to drive supportive policy, to advocate for and act as a role model for collaborative behaviour at the service-delivery level, and to make joint decisions regarding the national management of collaborative primary health care services. This represents an enormous level of change and requires commitment at the national level between all key stakeholder groups, including peak bodies and consumers. This commitment can be implemented in the form of a *National Primary Health Care Professional Forum* that will address:

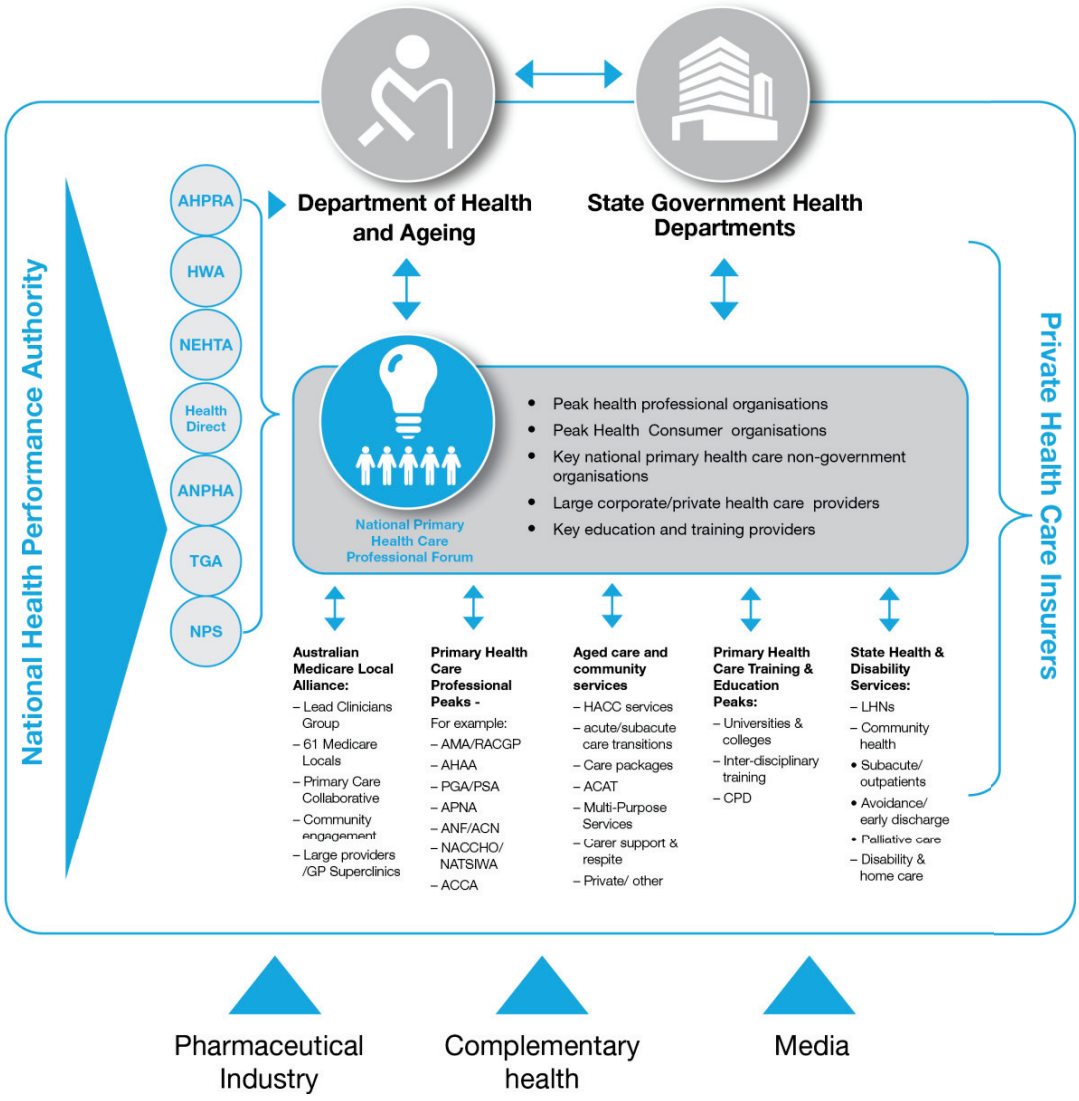
- The ingrained silos between health profession and different standards of practice
- The inadequacy of funding models
- The limitations of policy and legislation
- The need to integrate the delivery of care across the continuum of care regardless of the funder
- The need to connect all current funding programs and initiatives
- The need to prioritise and direct funding to the appropriate locations.

For the *National Primary Health Care Professional Forum* to be a success, and provide an effective mechanism for leadership and collaboration, the peak bodies that currently have opposing views and policy positions will need to identify areas of collaboration and alignment and reach a better understanding of each other's professional roles. If agreement cannot be reached, points of compromise need to be identified. It is important that this constructive and progressive discussion forms the basis of the *National Primary Health Care Professional Forum's* purpose and operations. Table 16: Function of the *National Primary Health Care Professional Forum* outlines what success and failure of this Forum would look like.

Table 16: Function of the *National Primary Health Care Professional Forum*

Success of this Forum looks like…	Failure of this Forum will be when…
• The big issues are resolved by health professionals • Consensus is built amongst health professionals • Local level health professional's views are fed upwards and implemented nationally • Resources are allocated based on agreed need • Clinical practice is constantly modernised with evidence-based, efficient new models of care	• Discussions centre around issues with minimal local impact and are not solution focussed • Forum participants look only to Government to act rather than driving change through their own collective influence and implementation arms. • Government and Health Authorities are not engaged in the remit or the recommendations of the group • Participants are professionally focussed rather than system or consumer focussed.

Figure 32: The National-Level Model for Professional Collaboration



What is the National Primary Health Care Professional Forum?

Purpose:

The *National Primary Health Care Professional Forum* is a collaborative partnership between all the key stakeholders in primary health care delivery. There is a shared vision, goals and building of consensus between partners who all share in decision-making. The *National Primary Health Care Professional Forum is a mechanism fo*r enabling alignment and agreement between primary health care professional groups on key policy and funding priorities. It is only through discussing their similarities and differences that these primary health care professions and providers will be able to establish professional trust and respect and understand how roles and responsibilities should work under truly collaborative care practices and advocate for this across the various professional groups.

It is envisaged that through this group, policy makers and funding providers can gain alignment of stakeholder input and advice regarding future policy and funding directions. The premise of the *National Primary Health Care Professional Forum* is to foster and support professional collaboration within the primary health care sector for the improved: (1) health outcomes of the Australian population; (2) professional reward of providers; and (3) experience of consumers and carers.

Participants of the *National Primary Health Care Professional Forum* are also representative of on-the-ground delivery and implementation drivers of the system. The outcomes of the *National Primary Health Care Professional Forum* are, therefore, able to be actively communicated and driven downwards through the appropriate channels. Similarly, issues and needs at the regional and local level also have the ability to be fed upwards to policy makers and professional bodies/colleagues for consideration in regards to any actions.

Theoretical rationale:

Research examining the concept of group identification and effective intergroup relations and conflict has been largely guided by social identity theory (Tajfel, 1978; Tajfel and Turner, 1979) and intergroup contact theory (Allport, 1954). Contemporary accounts incorporate aspects of both theories and suggest that intergroup contact in combination with a dual identity (i.e. individuals' identification with both a work group that addresses specific issues and an organisation) is a means by which to achieve positive intergroup outcomes. In this instance the *National Primary Health Care Professional Forum*, as an initiative, increases contact between the professional groups at the policy level and provides a secondary identity to their organisation/professional group. This aligns with system based thinking and considers the systemic impact of individual peak body actions.

Membership:

The *National Primary Health Care Professional Forum* membership includes: peak health professional organisations; peak health consumer organisations; key national primary health care non-government organisations; large corporate/private healthcare providers; and key education and training providers

Governance:

It is proposed that the *National Primary Health Care Professional Forum* a*cts as a* self-governing body with a rotating chair and secretariat responsibilities. In this way, their meetings should be self-determined, voluntary and address the issues that are inhibiting the progression of the primary health care sector at any given time. While it is expected that the *National Primary Health Care Professional Forum* w*ill determ*ine its own terms of reference, it is expected that one of the standing agenda items of each meeting should include Professional Collaboration and actions that have supported its progression.

Benefits:

The key benefits include:

- System efficiencies
- Alignment of peak primary health care provider organisations towards a common goal
- Advocacy for collaborative practices and codes of conduct between primary health professionals.

8.4.1 Building on existing infrastructure

The model of professional collaboration does not aim to create new and separate systems, but to leverage and build on existing infrastructure. It also recognises that current health reform is underway and working to reduce bureaucracy and duplication. Aligning with this, the model aims to link existing resources and use a new advocacy body to effectively disseminate communication and policy, both to policy makers and to those responsible for implementation.

The National Primary Health Care Partnership has already attempted to be formed for this purpose. However, without the necessary buy-in from some key primary health care peak bodies and the endorsement of DoHA, this body will not be able to achieve its objective: to provide a collaborative forum to strengthen the primary health care sector with a consumer focus.

With no new money for the proposed model, the National Primary Health Care Partnership is a good place to build a foundation for the *National Primary Health Care Professional Forum*. The governance and reporting model of the *Lead Clinicians Group,* with support for implementation from the Australian Medicare Local Alliance, provides a working example of how the forum might be implemented.

8.4.2 Actors, roles and relationships

Within each system there are roles and relationships that define how the actors interact.[25] Table 13 summarises the role of each actor (depicted in Table 17 below) and the relationships they have with one another.

Table 17: Actors, roles and relationships in the national level model

Actor	Roles and relationships
Department of Health and Ageing (Federal Government)	Under this model, **DoHA** will continue to work with states and territories on system-wide primary health care policy with advice from the collective decision-making processes of the *National Primary Health Care Professional Forum* – including how better collaboration can be achieved to improve system integration or service planning.
State and Territory Governments	Under this model, the *National Primary Health Care Professional Forum* would, through collective decision-making processes, provide expert advice to the **State and Territory Governments** and advocate for policy and funding changes as appropriate and relevant to collaboration.
Federal Government authorities –	These agencies would provide evidence and reporting for consideration by the *National Primary Health Care Professional Forum* as relevant and/or available. Specifically their roles may include the following: **Australian Healthcare Provider Registration Authority (AHPRA)** act as a liaison between the *National Primary Health Care Professional Forum* and the respective Health Profession Boards – in particular regarding Codes of Conduct. **Health Workforce Australia (HWA)** can potentially provide expert advice and research to the *National Primary Health Care Professional Forum* on health workforce planning, policy and training. **Therapeutic Goods Administration (TGA)** could potentially provide the *National Primary Health Care Professional Forum* with expert advice on the safety, effectiveness and quality of Registered medicines, listed medicines, or complementary medicines prescribed, dispensed and sold in Australia from which the *National Primary Health Care Professional Forum* can collectively support policies regarding their best use in primary health care practice. **National eHealth Transition Authority (NEHTA)** can liaise regarding approaches for implementation and use in primary health care. **Australian National Preventative Health Agency (ANPHA)** and the *National Primary Health Care Professional Forum* can work together to develop and support prevention policy. **Healthdirect Australia is an initiative of the Council of Australian Governments (COAG)** and provides access to health advice and information 24 hours a day, seven days a week, supported by

[25] "Actors" in the context of this model refers to the key players involved

Actor	Roles and relationships
	registered nurses, electronic decision-support software and algorithms to provide safe and effective health triage, information and advice to callers. Healthdirect Australia and the *National Primary Health Care Professional Forum* can work together regarding the linkage between telehealth services and primary health care service provision. **National Prescribing Service (NPS)** is an independent, evidence-based and not-for-profit organisation providing consumers with the tools and knowledge to help them make better decisions about their health and medicines and keeps health professionals up to date with the latest evidence-based information from which the *National Primary Health Care Professional Forum* can collectively support the NPS in its role in the safe use of medications.
National Health Performance Authority (NHPA)	**NHPA** will play an important role in feeding back relevant performance information to the *National Primary Health Care Professional Forum* for collective action as required. NHPA are currently working on appropriate indicators and measures of primary health care performance.
National Primary Health Care Professional Forum – Peak bodies for professions, consumer and carers	The new *National Primary Health Care Professional Forum* will: • Demonstrate to government its commitment to a collective model of care • Provide collective thought leadership and advice on primary health care policy and strategy to government • Develop standards of practice in relation to the collaborative model of care at local/regional levels • Provide a collective 'one-stop' primary health care stakeholder consultation mechanism for government • Provide collectively agree
Private Health Insurers	**Private Health Insurers** have the potential to be an actor in the development of Professional Collaboration models of care. Advice should be provided to and sought from this group by the *National Primary Health Care Professional Forum*.
Implementation arms: • Australian Medicare Local Alliance (AMLA)	**AMLA** has a key role in the national leadership of primary health care and will work with a wide set of stakeholders.

Actor	Roles and relationships
• Professional peak bodies	As well as being members of the *National Primary Health Care Professional Forum*, the **Professional Peak Bodies** will play an integral management and advocacy role in regards to implementing and supporting collaborative practice.
• Education and training	As an outcome of the *National Primary Health Care Professional Forum's* initial points of business, it will be necessary to implement a national curriculum of education and training that supports the strategies identified in relation to working as part of a modern interdisciplinary primary health care team. This should be implemented through universities and as part of continuing professional development, further education and training programs, and conferences.
• State Health and LHNs	**State health services and LHNs** will play an integral role in communicating and advocating for collaborative practices in primary health care services for which they have delivery responsibility.
• Aged Care Services	This stakeholder group will play an integral role in advising the *National Primary Health Care Professional Forum* as well as in on-the-ground implementation monitoring and feedback.
External environment / forces:	Although not within the scope or boundaries of this model, it is worth recognising the impact of external forces on the primary health care model of collaboration.
• Pharmaceutical Industry	The commercial/economic forces created by the **pharmaceutical industry** are considered to be outside the boundary of the model but should be recognised and managed as appropriately.
• Complementary health	**Complementary medicines** (also known as 'alternative' medicines) are regulated by the TGA, a key actor in the proposed model.
• Media/ mainstream health advice	The role of the **media** and access to online health advice and information is an important evolution in contemporary health care and is an external force that should be leveraged and harnessed as appropriate.

8.4.3 National model: key elements and performance levers

The seven key elements and performance levers described previously have been applied directly to the national model, more specifically, the *National Primary Health Care Professional Forum*. As an output of this model, it is necessary that all stakeholders involved discuss, understand and align their views on the key strategic policy, governance and funding decisions which are required to foster a collaborative care culture and to deliver against population health needs nationally. The policies and strategies identified as priorities and actions under this model are dependent on peak body and policy makers' willingness and preparedness to collaborate to produce transformational policy change in the primary health care sector. For more detail around the evidence supporting the suggested elements, please refer to the *Professional Collaboration Full Final Report.* The key elements of the model and performance levers are outlined below.

Policy and strategy

The policy and strategy focus of the *National Primary Health Care Professional Forum* and the national-level model should consider the following as initial business: (1) a policy framework that sets clear p*rocedures* for collaboration between all primary health care professionals; (2) the definition and redefinition of the roles, scopes of practice and linkages of individual primary health care professions in the consumer journey. It is noted that prior to meeting as one group it may be necessary for individual professions to meet and find alignment in policy views.

Funding

The proposed model works on the assumption that there is no new money available to promote professional collaboration. Therefore, in relation to funding models, it will initially be necessary for the *National Primary Health Care Professional Forum* participants to:

a Commit to the time and effort required by their organisation to progress this system-based approach to primary health care leadership. International experience suggests this collective investment is a necessary component to establish

"buy-in" to the outcomes of the initiative (Agency for Integrated Care Singapore, 2012). There are national and international models of self-funded initiatives where participants consider the opportunity to outweigh the cost.

b Identify potential ways to leverage off existing policy and funding models

c Learn from and leverage off existing 'pockets of excellence' nationally. These should be initiatives that already utilise a systems-based approach that embrace the key enablers to collaboration. (Examples of such Case Studies are available in Section)

d Identify any potential shifts/redistribution/redesign of existing funding streams and models that better align to the way care is most effectively delivered from the consumer perspective..

e Discuss, identify and advise on the best use of any new (or recurrent) funding available from state or national governments based on the collaborative decision-making processes developed by the *National Primary Health Care Professional Forum* .For example, international research suggests that fee-for service reimbursement creates perverse incentives to cooperation, coordination and team based care which is required for integration, collaboration and effective care delivery (National Patient Safety Foundation, 2012). This may be something the *National Primary Health Care Professional Forum* decides to consider in more detail. A description of current funding models are available above in Table 15.

Governance and standards

The proposed model requires a level of self-regulation and governance by the individual professions and the *National Primary Health Care Professional Forum* members. It is therefore imperative that the *National Primary Health Care Professional Forum* collectively defines a specific standard for collaboration between primary health care professionals that incorporates the existing mechanisms for monitoring health industry standards including authorities, guilds, associations, acts, regulations and peak bodies. It is envisaged that this would then serve as a level of practice to be fostered, advocated and upheld by the professions individually and collectively in the *National Primary Health Care Professional Forum*. In addition, it is recommended that the *National Primary Health Care Professional Forum* consider the creation and/or adaption of specific standards for professional collaboration in primary health care (e.g. ACSQHS) to support and develop the standards of practice and governance mechanisms.

Measures

To date, there has been little analysis of primary health care service performance and outcomes. Outcomes of collaboration as identified by the *Professional Collaboration Literature Review (5th Commu*nity Pharmacy Agreement, 2012) were grouped into three broad categories being: (1) consumer outcomes; (2) health professional/workforce outcomes; and (3) organisation/system outcomes. Currently, NHPA are developing key performance indicators and measures for the purpose of monitoring and evaluation of progress against objectives identified in the National Primary Health Care Strategy. Performance and outcome measurement will be required nationally at three levels:

Consumer outcomes – which might include better health outcomes for local populations, improved satisfaction with services delivered, better continuity of care, improved health literacy of local populations etc.

- Health professional/workforce outcomes – which might include improved respect and better understanding of roles, the perception that mechanisms to support collaboration are in place, better communication between health professionals, local-level training, education and forums etc.
- System outcomes – which might include avoiding adverse drug events, adherence standards/accreditation outcomes, reduction in avoidable admissions to acute care, reduced average length of stage in hospitals, cost reductions in care etc.

The proposed NHPA Measures for Medicare Locals are at **Error! Reference source not found.**.

Communication and linkages

Key focus areas for the *National Primary Health Care Professional Forum* and its respective implementation arms will be the communication processes and aligning key messaging regarding the following:

- Information management – includes knowledge sharing, standards of information format, content timeliness and utilisation of eHealth as a tool for enhanced collaboration.

- Interprofessional – this might include appropriate and timely referrals, common consumer care pathways and plans, consumer safety requirements, examples of good and bad collaboration practices, combined interdisciplinary CPD opportunities etc.
- Intraprofessional – this might include benefits of collaboration and standards of practice, a scope of practices in relation to other health professionals etc.
- Upwards – this might include communicating to government with an agreed solution and plan, providing on-the-ground insights supporting desired change etc.
- Downwards – this might include communicating consistent and aligned messages across professions that fast-tracks changes, advocate for professional collaboration through multiple networks etc.

8.4.4 Challenges to implementation

There are several potential challenges to implementing this model that should be recognised. Table 18 summarises these challenges and potential actions that need to occur in order to manage these.

Table 18: Potential challenges to implementation

Potential challenge	Likelihood	Mitigation
Mediating between powerful interests	High	**Rationale:** Fierce professional loyalty and intergroup discrimination is a common human trait well studied by social theorists. Threats to the status quo, potential loss of power or the idea of sharing resources is likely to trigger intergroup rivalry and conflict. **Action:** For this reason, it will be necessary for the *National Primary Health Care Professional Forum* to: (1) Plan to mediate between powerful interests within the *National Primary Health Care Professional Forum* and at the regional/local level; and (2) Gain commitment from *National Primary Health Care Professional Forum* members to act cooperatively and to work together to reduce conflict.
Lack of willingness and commitment from peak bodies to collaborate	Moderate – High	**Rationale:** One point of agreement identified through this project is that current policy, funding and legislation impede professional collaboration and while there is general agreement that transformational change is required, there is little political imperative to act in the current environment of visible interprofessional and intraprofessional tensions. The *National Primary Health Care Professional Forum* has the potential to act as a forum for addressing these issues in a balanced environment focused on collective problem-solving which also then has the collective weight of advice to policy makers. It will need *t*o be clear that, if endorsed by DoHA, declining a position in the *National Primary Health Care Professional Forum,* professional groups will be declining a voice in future policy decisions. **Action:** Gain DoHA endorsement for the *National Primary Health Care Professional Forum* (once established and active) to act as a collective advisory group on primary health care matters.
Lack of alignment in views within professions	Moderate – High	**Rationale:** Divergent intraprofessional views often reduce the potential ability to provide a definitive professional opinion or position in wider forums. In this way, it will be necessary for intraprofessional collaboration to take place on key issues. **Action:** Each profession should seek to 'get their house in order' and resolve, to an extent, the issues currently impacting their professions..
The *National Primary Health Care Professional Forum* becomes a 'phoney partnership'	Low	**Rationale:** The act of partnering or meeting with another group does not represent partnership or collaboration. Meetings for the sake of meetings will not progress this model and will not provide the leadership and role modelling required. For this reason, it will be a key success factor that each key stakeholder group has a commitment to authenticity of and outcomes for the *National Primary Health Care Professional Forum*. **Action:** Request each organisation to sign a commitment to the objectives of the *National Primary Health Care Professional Forum* and reconfirm this at meetings and through public statements.

8.5 A regional/local model for professional collaboration

The ability to deliver accessible and locally responsive services in a coordinated and integrated manner is central for improving the Australian health system. Health care is too complex for a one-size-fits-all solution. It is therefore important for local decision-makers and planners to choose a set of complementary solutions, structures and processes to create an integrated health system that fits the needs of local populations across the continuum of care.

A key structural element of the current health reform is the establishment of 61 Medicare Locals which build on the experience of Divisions of General Practice. A total of $477 million over four years was allocated to establish this national network of primary health care organisations across Australia, with $171 million in recurrent funding. Medicare Locals are a regional or meso-level primary health care organisation that sits, in terms of structure, between the national and local levels.

These local primary health organisations (PHOs), which also may be considered 'regional' (referring to the local region) or 'meso-level', have responsibilities for integrating health services and addressing population health needs and are a key element of structural reform in many countries including the UK (Primary Care Trusts and Community Health Partnerships), Canada (Divisions and Departments of General Practice and Local Health Networks) and New Zealand (Primary Health Organisations).

Like similar organisations around the world, they have an ambitious mandate to use population health planning to integrate innovative local service design and provision with the social, environmental, and economic determinants of health. A key feature of this strategy is the introduction of locally based powers for decisions for provision of primary health care services for local populations. At the time of their establishment, Medicare Locals were mandated with the ambitious objectives of:

1. Improving the patient journey through developing integrated and coordinated services
2. Providing support to clinicians and service providers to improve patient care
3. Identifying the health needs of their local areas and development of locally focused and responsive services
4. Facilitating the implementation of primary health care initiatives and programs
5. Being efficient and accountable with strong governance and effective management.

In practical terms, to date this has translated into:

- Linking local GPs, nursing and other health professionals, hospitals and aged care, Aboriginal and Torres Strait Islander health organisations
- Planning and supporting local after-hours face-to-face GP services
- Identifying where local communities are missing out on services they might need and coordinate services to address those gaps
- Supporting local primary care providers, such as GPs, practice nurses and allied health providers, to adopt and meet quality standards
- Being accountable to local communities to make sure the services are effective and of high quality
- Working closely with Local Hospital Networks to ensure primary health care services and hospitals work well together for their patients.

The concept of Medicare Locals provides enormous potential for the Australian health care system to 'operationalise' systemic and population health planning changes locally. This in turn will drive changes in the configuration of local services leading to the improved health of the local community. They are also the vehicle for local health care professionals to lead and influence innovations in care, improve the safety and quality of the delivery of primary health care services, and actively participate in collaborative and integrated primary health care services.

Collaborative care at the regional/local level involves an interdisciplinary team working in a systematic way to ensure that consumers are engaged in their care, are informed about their conditions, and receive the appropriate level of care according to evidence and best practice.

Consumer safety and consumer experience are at the core of why change is required at the local, regional and practice levels of primary health care. The current fragmentation between individual care providers means unnecessary complication in the consumer journey, as parts of their care are funded and governed by multiple entities. Better communication, collaboration

and connectivity of care are essential in improving the health outcomes of all Australians and preventing potentially adverse events.

Better communication, collaboration and connectivity of care are essential in improving the health outcomes of all Australians and preventing potentially adverse events. The evidence for this is clear. In Australia last year:

- Up to 115 prescribing errors per 100 high-risk patients were reported and up to 2% of prescriptions filled were reported as having a supply error (National Prescribing Service, 2009).
- A study of adverse drug events in general practice patients in Australia found that 23.2% were preventable and 7.6% resulted in hospitalisation (Miller et al, 2006).
- A study of Australian health provider consultations found that 13% were missing relevant patient information (National E-Health Transition Authority, 2011).

Collaborative care at the regional/local level involves a multidisciplinary team working in a systematic way to ensure that consumers are engaged in their care, are informed about their conditions, and receive the appropriate level of care according to evidence and best practice.

Despite the existence of numerous funding incentives for planning care, the delivery of primary health care to consumers is still fragmented. While eHealth reforms potentially provide a tool to enable better connections between health care providers, they will not replace the key requirements of a collaborative relationship between providers. Currently, there is no governance structure that supports the interaction of multidisciplinary primary health care professionals at the local or regional level and level and quality of relationships and communication between providers varies on an individual basis. While Medicare Locals, as new organisations, have been given a mandate by DoHA for clinical governance, these are early days. The national framework is in its early stages and the level of influence or power of Medicare Locals is unclear.

While eHealth reforms provide a potential tool for the purpose of enabling better connectivity between professionals, it will not replace the key requirements of a collaborative relationship between providers.

The level and quality of relationships and communication between providers varies on an individual basis. This can include incomplete consumer information or notes for handover of care, lack of feedback regarding consumer outcomes, or at the most serious end of the spectrum the failure to raise (e.g. due to lack of confidence) or to acknowledge a consumer safety issue when raised by another health care professional.

Currently, there is no governance structure that supports the interaction of multidisciplinary primary health professionals at the local or regional level. While Medicare Locals, as new organisations, have been given a clinical governance mandate by DOHA, any framework for this to occur is still in its early stages at a national level and the level of influence or power available in specific situations is unclear.

8.5.1 Overview of the regional/local model

The key objective of the regional/local (meso-level) model is for the needs of the consumer to be the central focus, through enabling a localised collaborative care partnership. In doing so, it attempts to depict that the consumer can enter a '*Primary Health Care Collaboration Partnership*[26] through any primary health care professional, where every consultation with a primary health care professional is an opportunity for better health outcomes, and can be appropriately advised and/or referred on the basis of clinical need.

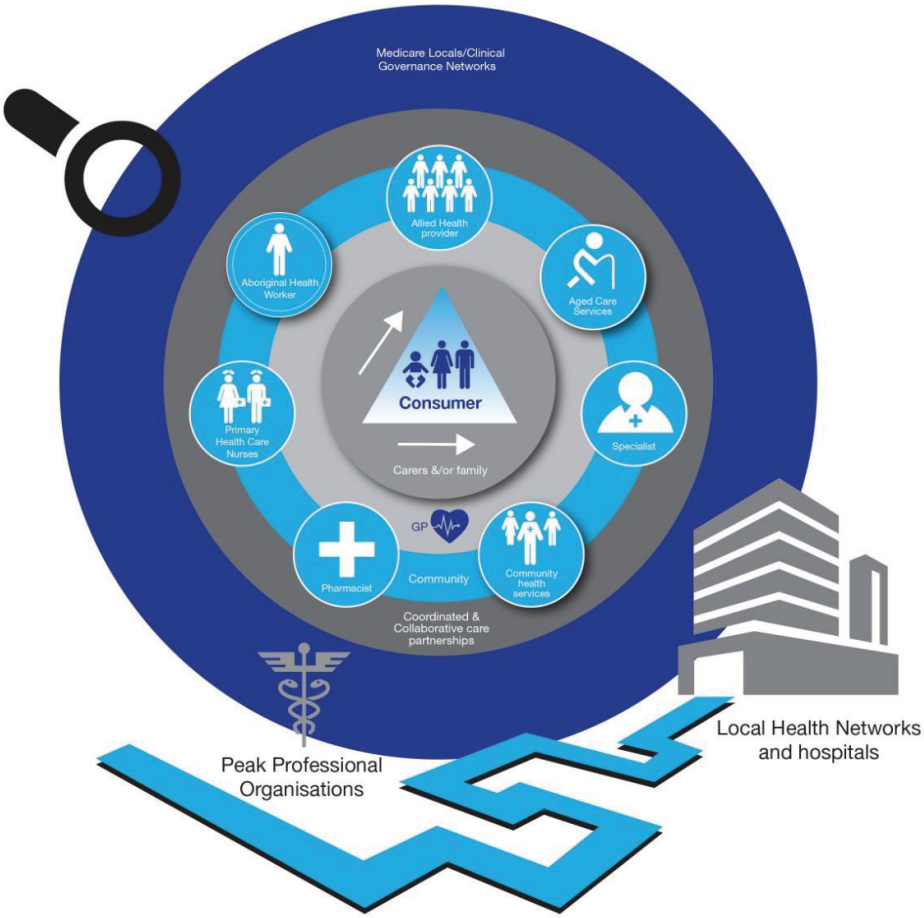
It is the role of Medicare Locals to progress intraprofessional and interprofessional collaboration between primary health care providers at the regional and local levels, and therefore they should have an interest in supporting local providers that wish to form a collaborative partnership.

A key initial step to enabling the model at this level will be developing a shared understanding of: the key barriers to collaboration; the services and skills available within the region and any gaps; the roles and scope of practice of health care providers in the region (building on the work of the *National Primary Health Care Professional Forum*); and existing opportunities for co-location/integration of services.

[26] '*Primary Health Care Collaboration Partnership' is a working definition/title* referring to a defined group of local primary health care providers that opt in to participate in collaborative care arrangements.

In the model seen in Figure 33, the consumer is represented by the pyramid shape to highlight the range of health need – from prevention through to those with highly complex needs and management requirements. In this way, the model also seeks to include the provision of health care advice and prevention, rather than just the treatment or management of illness.

Figure 33: Regional/local model



The collaborative partnership of care providers maps and connects the various primary health professionals that have contact with consumers, based on how the consumer chooses to access care. In this model, every consultation or contact with a primary health care professional is an opportunity to access the network of primary health care providers within the collaborative care partnership.

The research of the *Professional Collaboration* project suggests that this model exists to some extent in some pockets of practice in Australia. Progress on this model has been made on the basis of the goodwill, energy and commitment of individual providers and the work of their respective Medicare Local (and Division of GPs prior to this) and/or LHN. In these instances, the proposed model can formalise the structures and relationships that currently exist to allow them to have greater support at a national level.

The findings of the project also suggest that these models include only some of the primary health professionals and rarely stretch to include key participants such as community pharmacists.

The key success factor for the local-level model will be the extent to which collectively, professionals can identify the root cause and barriers to their service collaboration and identify the potential pathway to and benefits of collaboration. An example of work done in this area has been through the Pathways project – implemented in Canterbury New Zealand and locally in the Hunter Region, NSW.

8.5.2 Building from existing infrastructure

The local-level model assumes that there are no additional resources and aims to better utilise and define the roles of existing organisations and infrastructure. It also recognises that due to recent reforms, the required infrastructure to support better collaboration largely exists and has the potential to deliver these collaborative outcomes. Given this, Medicare Locals form the basis of the regional/local model. While GP Superclinics and the Primary Care Collaboratives program provide resources through which to implement trial sites for collaborative practice partnerships and other supportive initiatives. Telehealth (and the opportunities available through mHealth) are also relevant in this context.

8.5.3 Actors, roles and relationships

8.5.4 Actors, roles and relationships

The collaborative partnership of care providers, as illustrated in the model, maps and connects the primary health care professionals that have contact with consumers, based on how the consumer chooses to access care. The research of the *Professional Collaboration* project suggests that this model exists, to some extent, in pockets of practice in Australia. However, the development of such collaborative working methods is largely the result of the goodwill, energy and commitment of individual providers and the work of their respective Medicare Local and/or Local Health Network.

The key success factor for the local-level model will be the extent to which professionals can collaboratively identify the specific barriers to service collaboration and ways to overcome these. Within each system there are roles and relationships that define how the actors interact. Table 19 below summarises the role of each actor depicted in Figure 33 above and the relationships they have with one another.

Table 19: Actors, roles and relationships in the local level model

Actors	Roles and relationships
Consumer	The **consumer** is depicted by the pyramid shape to represent the range (and proportion) of consumers that access primary health care services with variable needs. Within this model, the consumer has a choice of where they access the primary health care system and requests advice and/or treatment.
Carer and/or family	The **carer and/or family** are represented in the model as the context within which a consumer exists. This recognises the support structures and interdependencies that exist for individuals between those that care for them or those that they care for. Where possible, the presence of a carer and/or family support network should be an active consideration in the care of an individual.
Community (this includes the local government and social services)	Primary health care deals with the complex interaction of biological and social causation of illness and is more frequently being asked to consider and leverage the social context of patients and communities. **Communities** provide primary prevention activities and should be considered a partner in delivery of primary health care.
Medicare Locals/ Clinical governance networks	• Like similar organisations around the world, **Medicare Locals** have an ambitious mandate to use population health planning to integrate innovative local service design and provision with the social, environmental, and economic determinants of health.
Collaboration Care Partnerships	• Involves a defined group of local primary health care providers that opt in to participate in collaborative care arrangements • Population health needs to inform strategy and priority areas identified as focus • Agree consumer needs assessments/diagnosis protocols – risk factors, self-management capacity, communication to the team • Agree processes for establishing individual consumer plans and working towards same objectives

Actors	Roles and relationships
	• Policies/procedures within local areas reflect the collaborative model, and are appropriate for that location • Defined local referral pathways, procedures and protocols agreed, documented and communicated (including templates as required) • Defined funding mechanisms and allocations for provider participation/role • Defined communication protocols to maximise patient outcomes (e.g. case meetings, shared electronic data records) • Continuous improvement programs feedback and evaluation loops
Individual providers: • Allied health care providers • Community pharmacists • Aged Care Services • GPs • Primary health care nurses[27]	• Individual health care professionals can opt in to the collaborative care partnership arrangements; however, all health care professionals will be expected to abide by the collaborative care *"code of conduct."* • Practice level *accreditation* processes in relation to collaborative practice and incentive payments based on findings are potential mechanisms to monitor this. • Primary health care nurses may include: registered and enrolled nurses; midwives and nurse practitioners working as: maternal and child health nurses; general practice nurses; community health nurses; school nurses; occupational health nurses; rural nurses; remote area nurses; sexual health nurses; and mental health nurses.
• Aboriginal and Torres Strait Islander Health Workers	**Aboriginal and Torres Strait Islander Health Workers** and Aboriginal Community Controlled Health Organisations will have a significant level of expertise to share with other providers in the region as the practice within AMS's represents collaborative models of care between an interdisciplinary team.
• Community Health and Disability services	Similarly, the **Community Health and Disability services** will be familiar collaborative care practices from their sector that can be leveraged for this purpose.
Specialists	The following considerations should be made regarding the role of the **specialists:** • Specialists are an integral link between the acute sector and the primary health care sector. • Specialists working in private practice are often referred patients with complex or specialised needs by GPs.
Local Health Networks (including all State-funded primary health care services, e.g. community care services, subacute care in community, disability services and outpatient clinics)	**LHNs** often have a number of patients that inappropriately present to their Emergency Departments for primary health care services, or receive patients that require acute levels of care due to deterioration of illnesses that could be managed instead in the community by an interdisciplinary primary health care team. The LHNs also provide services that focus on managing patients in the community that either: a Require acute services, but not as an inpatient (e.g. HITH, palliative care, early discharge or avoidance programs) b Have long-term disability for which they receive community care services (e.g. HACC and disability services) Have recently completed an acute episode of care with the local hospital (e.g. ambulatory care, rehabilitation, cancer services)The benefit to LHNs to actively support collaboration is that if patients are able to access more appropriate care in the community which meet their needs, it reduces medical hospital admissions, hospital ALoS, hospital ED activity

8.5.5 Regional/local model: key elements and performance levers

The seven key elements and performance levers forming the context of a model for professional collaboration have been described in the previous section. Here, they are applied to the localising of the national model, the *National Primary Health*

[27] This list of Primary health care nurses is not definitive as the national workforce data set is incomplete (national registration commenced on 1 July 2010) and there is still debate as to which nurse types fall under the primary health care umbrella.

Care Professional Forum, for operation at the regional/local level. As with the national model, it is necessary that all stakeholders involved discuss, understand and align their views on the key strategic policy, governance and funding decisions required to foster a collaborative care culture and to deliver against population health needs for communities at the regional and local levels.

The policies and strategies identified as priorities and actions under this model are dependent on participants' willingness and preparedness to collaborate to produce transformational policy change in the primary health care sector. The key elements of the model and performance levers will include:

Policy and strategy

The success of the *regional/local* level model is reliant on the leadership and organisation of the Medicare Local to:

- identify the population health needs of their catchment;
- support local providers in achieving successful collaborative partnerships and networks that address these needs; and
- knowledge sharing amongst providers and primary health care organisations.

Having said this, it is the local providers and community that have the opportunity to drive the strategic direction of their Medicare Local, and provide information and policy direction to the *National Primary Health Care Professional Forum.* In this way, the consumer can enter a '*Primary Health Care Collaboration Partnership'* through any primary health care professional, where every Medicare Local supports and drives change.

Governance and standards

The model requires self-regulation and governance by the individual professions, as well as an interdisciplinary governance network at the regional level (supported by the Medicare Local). This should include a local set of practice standards, based on the national code of conduct established by the *National Primary Health Care Professional Forum*. Mechanisms for feedback, analysis and mediation will be required for work that does not meet the practice standards at the local level, as well as escalation measures for those matters which cannot be resolved. The regional/local-level support structure provided by the Medicare Local should also provide ongoing support of practice-level accreditation processes.

Funding

In time, the National Primary Health Care Professional Forum will propose specific funding mechanisms that can be applied locally, to recognise the contribution of each health care professional to consumer outcomes. Until this time, it is recommended that local collaborative partnerships of health professionals review the use of current funding packages and identify how to best utilise these resources to support and provide incentives for local collaboration. In addition to this, there should be local-level consultation mechanisms among the collaborative care partnership providers for how to direct and prioritise funds in relation to primary health care and population health needs

Education and Training

The education and training strategy for collaborative practices between primary health care professionals will ideally be set at the national level and supported by regional/local implementation. In addition, local health care professionals may wish to collaborate to further define competencies or specific training to be undertaken by interdisciplinary teams. A key feature of this should be an on-the-job mentoring program between senior and junior primary health care professionals. Regional/local education and training should also be considered as a mechanism to support change management.

Measures

To date, there has been little analysis of the service performance and outcomes of primary health care. The outcomes of collaboration, as identified by the *Professional Collaboration Literature Review (5th Community Pharmacy Agreement*, 2012), can be grouped into three broad categories with outcomes related to: (1) consumers; (2) the health profession and workforce; and (3) organisations and the overall system. Currently the National Health Performance Authority (NHPA) are developing key performance indicators and measures for the purpose of the monitoring and evaluation of progress against objectives identified in the National Primary Health Care Strategy, which are to be measured at the national and Medicare Local level. Based on these NHPA measures, and in line with national indicators for collaboration established through the *National Primary Health Care Professional Forum*, the regional level (Medicare Locals) should agree indicators for measuring change and effectiveness.

Australian research has suggested that measuring or evaluating partnerships (for example the number of interactions) adds limited value at the local level. This research suggests that it is instead better to measure achievement linked to collaborative working practices (Joss and Keleher, 2011). The proposed NHPA Measures for Medicare Locals and the potential measures of collaboration developed as part of the Design Forum are available in **Error! Reference source not found.**

Communication and linkages

Regular communication between health care professionals was identified as a key enabler to professional collaboration; it should be regular, active and transparent. Other findings related to communication and communication opportunities at the regional/local level are summarised in Table 20.

Table 20: Findings and opportunity

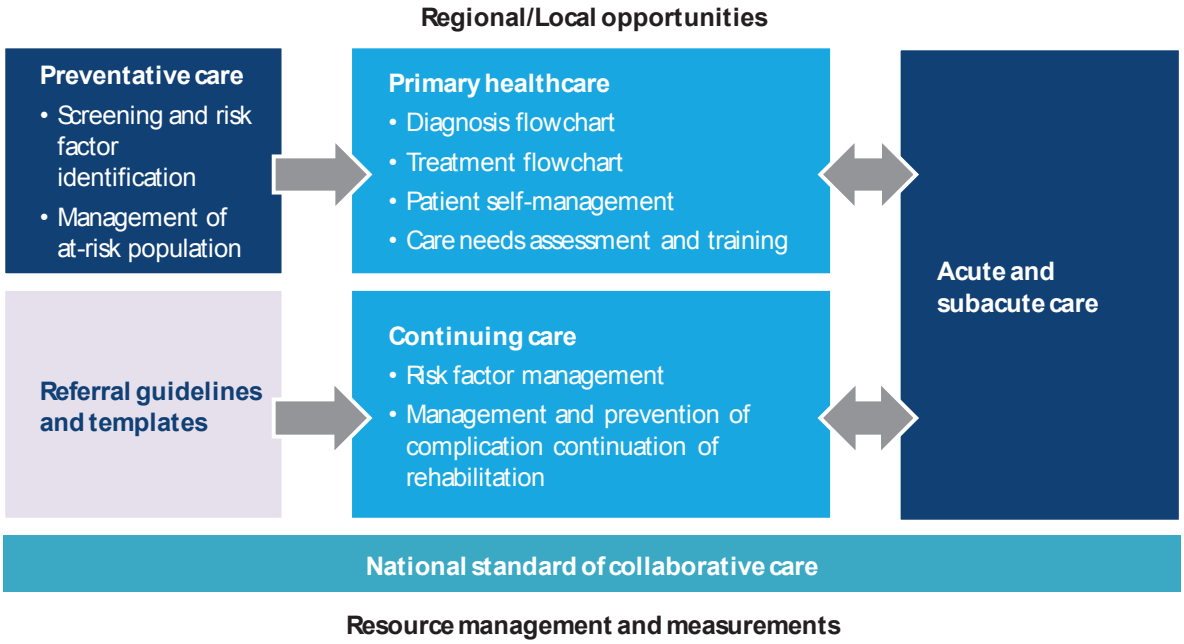
Finding	Opportunity
The preferred method of contacting and being contacted by other health professionals was reported as phone	• Use of technology to enhance telephone communication e.g. teleconference, telehealth, webinars and videoconferencing
Timely access to information, shared records and knowledge was a key enabler to collaborating	• Shared electronic health records and regular meetings, consumer case meetings
One-way communication with little acknowledgement or feedback	• Development of agreed guidelines/strategies around communication • Development of regional conflict resolution/mediation guidelines.
Acknowledgement of consumer safety risks	• Escalation procedures or 'communications hierarchy'
The system is fragmented and difficult to navigate for consumers and their carers. Health professionals are time poor with clinical duties as the focus of their time	• Liaison officers/local coordinators to support coordination of care • Guidelines developed to aid navigation process • Promote system coordination to consumers and carers to reduce demand on professionals

8.5.6 Potential opportunities at the local level

The potential to improve care at the local level through collaborative practice and planning is real. Internationally, many countries have identified similar opportunities with great success. It is appropriate that this process is organic and not prescriptive – except for the fact that it is undertaken with respect and positive intent and includes all stakeholders and providers involved in the care of consumers

Figure 34: Regional/local care path opportunities for chronic conditions below identifies potential opportunities to work collaboratively that will improve the efficiency of processes, health outcomes gained/morbidity avoided, and the overall consumer experience. Local level practices that are identified by peers to be innovative and progressive with improved consumer outcomes should be identified as role models for replication. Similarly these local level practices should inform both the regional and national level collaboration standards and guidelines.

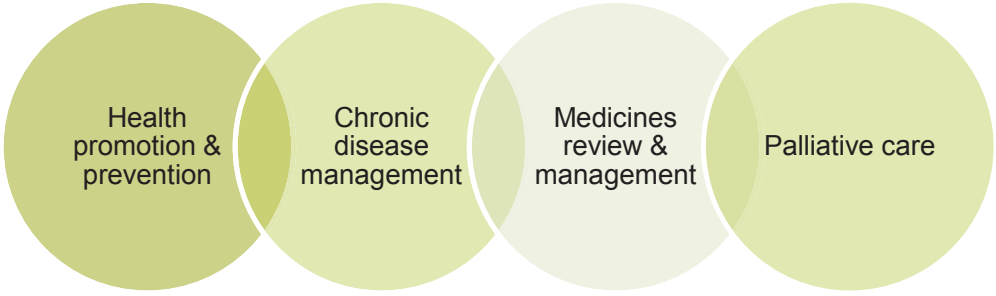
Figure 34: Regional/local care path opportunities for chronic conditions



Immediate opportunities

In progressing opportunities at the local level, it will be important to first understand the current context by performing a baseline assessment of collaboration between health care professionals and the potential barriers to collaboration. The four areas identified in the *Professional Collaboration Literature Review* (5th Community Pharmacy Agreement, 2012) are illustrated in Figure 35 as potential starting points for local initiatives, however these should also be considered against the specific population health needs priorities of the local area.

Figure 35: Four areas for potential focus of local initiatives



Includes aspects of prevention, early detection and diagnosis and assessment. For example: • Anticoagulation management • Blood pressure control • Cholesterol management • Osteoporosis screening • Education and awareness about smoking, nutrition etc.	Includes aspects of treatment and rehabilitation. For example: • Diabetes management • Asthma and COPD care • Cardiovascular disease management • Mental Health Community Teams • GP management plans	Includes aspects of treatment and rehabilitation. For example: • Home Medicines Review • Residential Medication Management Reviews	Includes aspects of palliative care. For example: • Medicines Review and Management • Education and Awareness

The previously referenced frameworks (i.e. International Pharmaceutical Federation Levels of Collaborative Practice, 2009 and the Collaborative Working Relationship model proposed by McDonough and Doucette, 2001) also recognise that with increasing collaboration between health care professionals, there is also an increasing level of responsibility and role clarity that should be recognised. For example providers that operate within a specific geographic area may meet at their Medicare Local office to discuss and progress:

- Access to after-hours care across all professions (this may include rosters and what hotline numbers to call)
- Referral processes , preferred diagnostic practices and opportunities for interdisciplinary care
- Safety and quality concerns relating to recent cases
- Preferred practices for care or risk escalation – who to contact and when
- Opportunities via private, not-for-profit or government funding grants for pilot projects
- Case conferencing for consumer cohorts.

8.5.7 Case studies

The following are case studies that involve collaboration of health professionals at the regional and local levels, they include: (1) the Health Pathways project; (2) Partners in Recovery; (3) Aboriginal Medical Services; (4) Inala Primary Care and (5) Gold Coast Medicare Local.

The Health Pathways project described below is an example where this level of discussion has improved care outcomes and consumer experience.

HealthPathways case study

HealthPathways is an example of a semi-structured organic approach to regional/local collaboration that has yielded measurable outcomes in efficiency. This has been demonstrated in both New Zealand and Australia.

HealthPathways is an online health information portal for GPs to be used at the point of care. It provides information on how to assess and manage medical conditions, and how to refer patients to local specialists and services in the most timely way. The name '*HealthPathways*' reflects the referral lines or 'pathways' which link patients to the best treatment, local service or specialist.

HealthPathways is aimed at General Professionals (GPs) but can also be used by hospital specialists, practice nurses/managers, and community and allied health providers. *HealthPathways* is the first online health information portal of its kind in Australia and is based on a highly successful model of collaboration developed in New Zealand by a group called the Canterbury Initiative.

Who is creating HealthPathways?

HealthPathways is a dynamic collaboration between Hunter New England Local Health District and Hunter Urban Medical Local. GPs, hospital specialists, nursing and community and allied health providers are all involved in creating HealthPathways and are invited to be a part of its continuing development.

Examples of some of the health pathways include Chronic Obstructive Pulmonary Disease, Chronic pain, Paediatrics (i.e. UTIs, food allergies, eczema), Maternity (i.e. anaemia, hypertension, epilepsy), Psychosis, Osteoarthritis, and wound management (i.e. burns, tears, cellulitis).

Over time, more work will be done to create extra pathways, according to demand.

Benefits

HealthPathways has been suggested to result in improvements such as:

- GPs and primary health care providers manage a condition or accurately refer a patient to local specialists and services in as little as a few seconds.
- More patients get the right treatment or specialist care with less waiting time.
- GPs are enabled to better help patients by outlining information their patients need to know.

Partners in Recovery

The Partners in Recovery (PIR) program funded by DoHA is an example of current models of collaborative practices; provided by a multidisciplinary team and is facilitated by one point of contact. A key feature of this program is that each team member signs an MOU which outlines their formal roles within the care action plan and regular review of progress against the plan.

Who is involved in Partners in Recovery?

PIR organisations aims to better support consumers experiencing severe and persistent mental illness with complex needs by engaging the multiple sectors, services and supports to facilitate a more collaborative, coordinated and integrated service delivery .

The range of organisations (local partners) engaged reflect the existing suite of sectors, services and supports required by the target group and PIR will bring these organisations together to promote collective ownership and development of innovative solutions to ensure timely and effective access for the consumer. Local partners may include: primary health care (health and mental health), state/ territory specialist mental health system, the mental health and broader NGO sector, alcohol and other drug services, income support services, as well as education, employment and housing supports.

The PIR program will employ Support Facilitators who will review referrals, undertake an assessment of the client's holistic needs and develop an action plan in collaboration with the local partners within the region to schedule and prioritise the delivery of services, engage with existing case managers and be the point of contact for clients, their families and carers (as appropriate).

What does a typical client pathway for Partners in Recovery look like?

1. Client admitted to local hospital with a history of sporadic engagement with community mental health and crisis intervention services, substance misuse and homelessness. Hospital Social Worker contacts PIR and local state clinical mental health team.
2. PIR Support Facilitator meets with the client to assess his needs and develops a step-by-step plan to access the services required.
3. The PIR Support Facilitator works with the client to clarify their personal recovery goals and associated service and support needs including: local supported accommodation, local Personal Helpers and Mentors service, Centrelink, community mental health services, a GP, drug and alcohol services, a dentist
4. PIR organisation has been established MOUs with local partners which outline how they work in partnership to support clients in the region. The client's recovery plan is discussed at the PIR working group which is composed of representatives from the local partners. They review and discuss the recovery plan before formally committing to their identified roles and contribution.
5. The local community mental health worker is established as the client's clinical case manager and works closely with the PIR Support Facilitator and the client to coordinate discharge planning a move into supported accommodation. The clinical case manager also arranges for the client to link in with a case coordinator team at the local Centrelink service centre and meet with a GP and psychiatrist. The case coordinator sends weekly updates to the PIR Support Facilitator about progress.

Aboriginal Medical Services

Aboriginal Medical Services (AMSs) are a network of providers who provide support to the Aboriginal Communities across a specific region. The services are largely community owned and controlled and funded to deliver specific health programs. The aim of the service is to provide holistic culturally appropriate primary health care services which include specific chronic disease, maternal health and health prevention programs.

Aboriginal Health Workers (AHWs) are a key feature of the AMS model and have specific training and qualifications related to their role in the health service. Primarily AHWs act as a cultural broker and point of coordination for care delivery for the Aboriginal or Torres Strait Islander community. Activities may include assisting clients to make and attend appointments, delivering health related education and screening and linking in with clinical services and supporting care pathways and patient monitoring.

Health Professionals involved in delivering services to the Aboriginal and Torres Strait Islander community from Aboriginal Medical Services include:

- GPs
- Nurses
- Aboriginal Health Workers
- Dental staff
- Pharmacists
- Allied Health Professionals
- Medical specialists

Some of these health professions are employed by Aboriginal Medical Services while others are visiting staff.

Services provided include:

- Clinical health care e.g. chronic disease management
- Population health programs e.g. immunisation
- Child and maternal health services
- Screening programs and health checks
- Access to allied health and specialist services

Information sharing

Care is coordinated through informational technology such as electronic health records (86% of Aboriginal Health Services use these) and multidisciplinary team meetings/case conferences e.g. for chronic disease management

For example:

- An Aboriginal or Torres Strait Islander consumer may visit a GP at a chronic disease clinic at the local Aboriginal Community Centre every fortnight. This clinic may involve a visiting nurse and supported by an Aboriginal Health Worker. During this visit, a chronic disease management plan may be reviewed and updated as needed.
- In addition to this, Allied Health professionals or specialists may visit the community centre on a regular basis to provide checkups and advice.
- The Aboriginal Health Worker provides support for the Aboriginal and Torres Strait Islander consumer during the chronic disease clinic and other visits and also when accessing other services outside of the community centre and involving the consumers' families and carers where appropriate.
- Care is coordinated through shared electronic health records that service providers are able to access and update as well as regular multidisciplinary team case conferences via teleconference.

Inala Primary Care

Inala Primary Care (IPC) was established in April 2007 as a collaboration between the University of Queensland and Queensland Health. The purpose and objectives of Inala are to:

- Provide best practice, patient focused primary care to disadvantaged urban communities
- Integrate healthcare to control and prevent the progression of disease
- Provide facilities for research, teaching and education
- Increase the skills available within the medical community
- Disseminate health information and models to facilitate improved health outcomes
- Reinvest surplus revenues into projects designed to moderate the impact of disease
- Promote the development and adoption of clinical standards and evidence based practice.

IPC's approach is defined in academic literature as Primary Care Amplification. This approach includes first assessing the healthcare needs of the catchment and then developing services and recruiting specialised clinical expertise to work within novel models of care. This usually involves creating localised team care and shared care arrangements.

IPC's approach has demonstrated success in managing even very complex patients, in a general practice setting, reducing the referral rate and admissions to acute providers.

IPC's promise is that "No patient will leave feeling like a number because every consultation makes a difference!"

Within their local area (QLD) Inala acts as a hub of ideas and professional development others healthcare professionals and practices can access, as well as a central setting for the delivery of specialised care needed in the local area and partnering opportunities for less specialised practices wishing to utilise avenues for local, low cost, high quality care.

IPC's core values reflect this focus and the way in which the teams work together. That is IPC is:

- Dedicated to making a difference for every patient
- Focused on innovation which matters to our patients and community
- Investing in people, relationships and systems to deliver great care
- Driven by passion for excellence in primary care, teaching and research
- Responsive to each other and flexible as we deliver care for others
- People you can trust and depend on who deliver results
- Courageous enough to change, learn and grow.

The IPC team includes a growing team of over eight fulltime equivalent doctors. They are ably supported by three practice nurses and a range of allied health providers who operate from the practice. In addition, the practice houses a fulltime Diabetic Educator, the Brisbane South Complex Diabetes Service and a Mental Health Nurse.

IPC has just over 300 patients concurrently enrolled in the clinic, which replaces the support traditionally delivered in hospital outpatient departments. In 2013 IPC aim to supplement this specialty by initiating new services for kidney and respiratory disease.

IPC is a not-for-profit company managed by a Board. Company Directors are drawn from the health sector, local community and the University of Queensland. All have management qualifications and experience, with most being members of the Australian Institute of Company Directors.

A Clinical Governance Sub-Committee defines IPC's research and clinical delivery priorities and approves any new research projects or clinical services. It also reviews the teaching program, any serious adverse events or near misses and recommends the clinical staffing complement and professional development needs of the business.

Medical Staff:	8.5 FTE doctors (Total Staffing 18.5)
Total Allied Health Attendances:	14 sessions across 5 disciplines per week
Expected Turnover 2012/13:	$2.1 million (excluding Allied Health revenues)
Patient Appointments Per Week:	550 per week serving over 2300 active patients
Average Patient :	55 years old (over 80% concession card)

Gold Coast Medicare Local

Gold Coast Medicare Local (GCML),and prior to this the Gold Coast Division of General Practice, have a long history in working towards collaborative coordinated care in their region. Listed below are some examples of how they achieve this:

Care coordination and Integration

As an organisation GCML have participated in and driven a number of projects addressing coordination of care and improved integration for the purpose of chronic disease management.

These projects have included:

- A gap analysis on clinician and consumer experience of the care journey
- Solution design of agreed referral protocols, transfer of care requirements, communication behaviours and feedback loops for multidisciplinary teams.

GCML were able to facilitate these projects by successfully tendering for research pilots and funding available through the Australian Primary Care Collaborative Program (http://www.apcc.org.au/). However the ongoing maintenance cost of running these programs includes minimal payments to participating practices for their administrative costs.

Allied Health Advisory Group

In 2011 GCML established the Allied Health Advisory Group (AHAG) of local allied health practitioners from each discipline (plus one proxy) as an advisory body for the newly established GCML. The first meeting of the GCML AHAG took place in November 2011. AHAG members include a:

- Dentist
- Dietician
- Exercise Physiologist
- Occupational Therapist
- Optometrist
- Pharmacist
- Physiotherapist
- Podiatrist
- Psychologist
- Speech Language Therapist
- Social Worker
- Gold Coast Health & Hospital Health Service representative
- Griffith University representative

Representatives are promoted through professional associations and within local networks. A flyer on the group and its role has been produced by AHAG members to help promote this forum as a conduit to integrated practice. Members are also listed on the GCML AHAG website and communicate through Gold Coast Medicare Local's HealthE Gold Coast Community online. AHAG meeting outcomes are published each month on the AHAG web page to ensure that all Allied Health practitioners are kept informed of opportunities, discussions and decisions.

The GCML AHAG provides strategic direction and leadership with regard to primary allied health care through comprehensive input into activities of the Medicare Local. Early in 2012 as part of the GCML community engagement strategy '*Taking The Pulse'*, the AHAG hosted an AH Forum to provide input into the health needs of the Gold Coast community and to discuss issues including integration, workforce development, and key priorities to progress allied health further on the Gold Coast.

The group's immediate objectives are:

- Establishing shared goals and strategies and contributions to meet these goals.
- Influencing policies and programs to enhance integrated primary health care.
- Planning an annual forum to showcase integrated care strategies.
- Promoting quality of practice through shared professional development and quality activities.
- Increasing community awareness of Allied Health role in primary health care.
- Leading innovative practice in integrated primary health care.

Afterhours Services

GCML recently addressed the lack of equitable access to pharmacy services afterhours in their region as part of their after-hours primary care services program. GCML consulted with local pharmacists and subsequently released an RFT to deliver extended services to midnight in one specific region f the GCML. The successful pharmacy received

8.5.8 Opportunities for Collaboration

Potential opportunities for local level collaborative care models that have been highlighted throughout this project include:

- Expert medication advice to be given by pharmacists as part of the primary health care team. This may include onsite support in relation to complex medicine regimes/needs within consultation rooms or in an appropriately designed and resourced pharmacy. Similar to the AMS model explored above this might include:
  - expert advice to Doctors and practice staff on medications,
  - consumer education regarding medication,
  - consumer monitoring and follow-up (after commencement of new medication),
  - dispensing and creation of Webster packs onsite
- On site allied health professionals that form part of an interdisciplinary team care arrangement that can be supported through current Medicare items for chronic disease.
- Practice Nurses have the skills and ability to play care coordination role as a central point of contact for the interdisciplinary team, with medical oversight by a GP.

Current attitudinal barriers to these types of collaborative practices occurring that need to be overcome in order for local level collaboration to progress:

- Perceived lack of standards and confidentiality practice in relation to consumer information. This includes consumer information not being shared with other health professionals due to "mistrust".
- Perceived lack of training of health professionals in specific elements of practice. In particular the perception that some professionals wish to practice outside of their skill set and/or scope of practice
- Perceived liability/legal risk in "sharing" the care of a consumer
- Perceived loss of status by GPs in collaborating with other health professionals (supported by survey responses)
- Perceived commercial agenda of pharmacists and allied health professionals in relation to consumer referrals and "up-selling" therapeutic treatments (e.g. treatments without an evidence base).

However, negative attitudes towards these types of collaborative practices still exist and need to be overcome in order for local-level collaboration to progress. These include a perceived:

- Lack of standards and confidentiality in relation to consumer information
- Lack of training of health professionals in specific elements of practice
- Liability/legal risk in 'sharing' the care of a consumer
- Loss of status by GPs in collaborating with other health care professionals (this point was supported by survey responses)
- Commercial agenda of pharmacists and allied health care professionals in relation to consumer referrals and "up-selling" therapeutic treatments (e.g. treatments without an evidence base).

As an outcome of the *Design Forum* participants created a list of potential protocols to support local level collaboration and relationship building.

Protocols for Collaboration

As an outcome of the Design Forum participants developed a list of potential protocols to support Professional Collaboration that addresses the current gaps and barriers identified throughout the Design Forum. Potential protocols for development that would support Professional Collaboration locally include:

- Referrals (Written /phone /electronic)
  - Reporting back (including required clinical information)
  - Address barriers to it being seamless (waiting times for patient access)

- Data flow – information to come with referral (e-health or minimum information/history)
- Inter-professional code of conduct/behavior s (e.g. Respect for each other/ Responses to referrals/ Feedback/ Waiting times/Access)
- Monitoring Performance of clinicians (e.g. By peers, Peak Bodies/Medicare Locals)
- Uniformity / Flexibility / Fluidity
- Practitioner training – Post graduate and ongoing professional development
- Funding / Publicity (Government)
- Education / Empowerment / Assisting the consumer through the system
- Communication:
  - Hierarchy of Escalation (issues resolution)
  - Responsibility to Patient
  - Safety standards
- Feedback Loops – post referral and treatment.

8.5.9 Challenges to implementation

There are several potential challenges to implementing this model. Table 21 summarises these challenges and the actions needed to manage them.

Table 21: Potential challenges to implementation

Potential challenge	Likelihood	Mitigation
Lack of willingness and commitment from professionals at the local level	Moderate	**Rationale:** Many health care professionals will be more concerned over the short-term benefits such as their bottom line than the long-term benefits **Action:** Consider performance levers at the national level to incentivise commitment to this model.
Lack of capability and capacity of Medicare Locals to facilitate and support the model	Moderate – High	**Rationale:** While it is one of their key strategic objectives, Medicare Local may be stretched to support the ongoing development of collaborative practice models or not know where to start. **Action:** Utilise AMLA to develop support and resources that are scalable nationally while the *National Primary Health Care Professional Forum* is established.
Time-poor provider engagement in education on collaborative practices	Moderate	**Rationale:** Engaging clinically focused, time-poor and people disengaged from changes at the policy level nationally and locally will require investment to make collaborative practice work. **Action:** Identify the benefits to the individual health care professional that will make them want to get involved in collaborative partnership care groups and arrangements
Change fatigue	Moderate	**Rationale:** The health care system is one of ongoing change and has had varying success in its implementation. Changing the way in which people work together is not a simple task and change fatigue and attitudes to change are likely to limit the pace and local success. **Action:** Active change management strategies will need to be in place at regional/local levels. This will need to go beyond just communicating change and will need to address the individual needs of various stakeholders

8.6 Considerations for change

Health systems around the world are trying to address escalating costs, poor quality care, and dissatisfied consumers; they are doing this by implementing strategies to improve and integrate the delivery of health care. Relevant literature focuses on the challenges of structure and process involved in integration. However, a barrier that is well acknowledged, for which there is no simple solution, is the failure of interprofessional or interorganisational collaboration (Evans and Baker, 2012).

For example, to date, there are only a limited number of examples of where the establishment of Medicare Locals has started to systematically improve the level of professional collaboration occurring at a local/regional level. This is due to stakeholders having variable time and capacity and offering variable support for leveraging pre-existing infrastructure to improve collaboration. In order for the proposed model of professional collaboration to be successfully implemented, the barriers of poor attitude and behaviour need to be removed.

At the same time, mechanisms to support collaboration need to be put into place via a systematic change management approach. The project has started to address some of Kotter's (1996) 8 steps for change (outlined in Table 22), for example starting to: (1) Establish a sense of urgency; and (3) Creating a shared vision for collaboration. The model of collaboration will continue to build on these while addressing the remaining steps including: (2) Forming a powerful guiding coalition; (4) Communicating the vision; (5) Removing obstacles to the new vision; (6) Planning and creating short-term wins; (7) Consolidating improvements and producing more change; and (8) Institutionalising new approaches.

Table 22: Change management and professional collaboration

Step	Description	How the model addresses this
Step 1: Establish a sense of urgency	Primary health care professionals must feel a need to carry out change. Without a compelling reason to change, they will have little motivation to do so. The sense of urgency needs to be established at a health care system level, highlighting the issues of an ageing population, increasing prevalence of chronic diseases, gaps in the delivery of health care and changes to legislation.	The case for change must be strong and relevant to stakeholders at all levels and all professions.
Step 2: Form a powerful guiding coalition	Major change initiatives require strong leadership which may not arise from a single individual or organisation. In changing primary health care delivery, leadership is required across the entire spectrum of primary health care delivery, from national, regional and local level and from professional bodies to local practices and individual professionals, carers and consumers.	In the model, the *National Primary Health Care Professional Forum* forms this leadership group across the spectrum of care.
Step 3: Create a shared vision for collaboration	A vision for primary health care needs to be created and/or endorsed. It should be appealing and easy to communicate. Without a clear vision, efforts towards change can disintegrate into unrelated, small projects that do not have the intended effect. In contrast, when there is a compelling vision, it can bring people together and motivate them to change.	Within the model, there is an opportunity to share and shape the vision at the local, regional and national levels.
Step 4: Communicate the vision	A common problem encountered in change is the poor or inconsistent communication of the vision. Communication of the vision has to be articulated well and aligned to the behaviours exhibited by leaders driving the change. Communication strategies also need to be extensive and ongoing to ensure a sense of continuity.	In this model, the communication of the vision is driven through the *National Primary Health Care Professional Forum* and the various implementation arms including the Medicare Locals.
Step 5: Remove obstacles to the new vision	To advance the vision and drive change, there needs to be an awareness of the obstacles to the new vision (barriers) and progress made towards removing them. If individual professionals see leaders taking concrete steps to address	After identifying and communicating the vision, this model allows for the barriers to collaboration to be addressed in

Step	Description	How the model addresses this
	such obstacles, they will feel more empowered to make changes in their own practice.	order of impact and priority.
Step 6: Plan and create short-term wins	Changes in practice involving individual professionals, practices and organisations, the government and other stakeholders can often take years to achieve. This can lead to a loss of momentum. Planning and creating short-term wins is important to provide evidence of the benefits of the new vision within a short period of time. Communication and change activities therefore need to focus on personal responsibility for change, and also the impact and benefit arising for each individual as a result.	The model allows the *National Primary Health Care Professional Forum* to prioritise the most pressing policy issues that will create most impact on the sector. Local and regional level models enable immediate action at the ground level.
Step 7: Consolidate improvements and produce more change	Until changes become deeply embedded into pharmacy culture, regressing to old behaviour is common. Leaders of the change initiatives will need to build on what has been achieved and learned so far and continue the momentum to change policies, systems and processes that do not promote the vision.	The sustainability of the model will be dependent on the ability to monitor and measure benefits, reflect on lessons learned and identify continuous improvements.
Step 8: Institutionalise new approaches	Practice change has to be institutionalised so that it becomes the norm in inter and intraprofessional culture. This requires extensive communication. Practice change will only become permanent when it becomes part of the shared values and social norm of the primary health care sector as a whole and individual professions.	The model requires systemic change, which will require a comprehensive change management approach. The model seeks to embed collaborative behaviours in education and professional standards of practice.

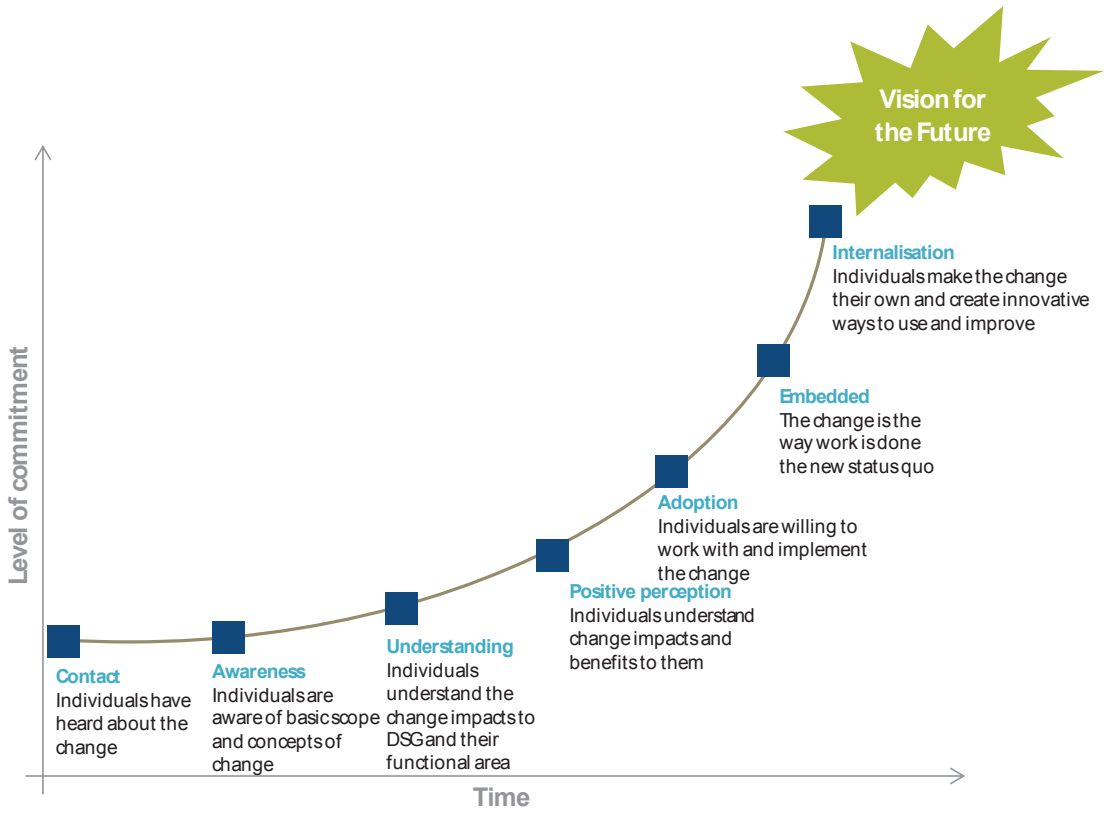
Many significant change initiatives fail due to cultural issues, rather than the structural or functional requirements of the change. This often relates to support of change by leadership figures, or resistance to change by individuals. Overcoming these attitudinal barriers and achieving successful change of this magnitude will require a change management program (as described above) to form the basis of the implementation plan.

Ultimately, for collaboration to work at the local or national level, enthusiasm alone is not sufficient to sustain momentum. Change like this will create uncertainty and ambiguity – and will therefore require continuous commitment and leadership from *all* participants over time.

The Commitment Curve (Conner and Patterson, 1982) shown in Figure 36 how commitment to implementing the model of professional collaboration could increase over time. It provides a tool to understand the different stages of commitment, with each stage acting as a critical juncture where commitment to change can be threatened or advanced. This allows for consideration of what should be done to prepare for change and how commitment can be developed and lost.

The speed at which individuals move through the commitment curve may vary depending on the magnitude of the change and the stage at which they commence. Some people progress quickly through the stages, while others are more resistant and take longer, requiring more support to fully commit to the future vision.

Figure 36: The commitment curve (Conner and Patterson, 1982)



As mentioned earlier in this section, resistance to change can often lead to the failure of change initiatives. In this light, the importance of readiness for change cannot be understated. Research has shown that change initiatives will fail if participants are not 'ready' to change (Armenakis et al., 1993). Change can sometimes create uncertainty and ambiguity which often leads to resistance to change.

Therefore, participants need to be motivated and ready to change. As such, understanding and accounting for willingness and readiness to change is paramount. Readiness to change can be understood in terms of participants' beliefs, attitudes and intentions towards the extent to which change is needed and the perception that change can be made successfully.

9 Conclusion and next steps

The key to achieving healthy communities is a strong primary health care sector where its parts are integrated and its health professionals work collaboratively together. This project examined the crucial issue of collaborative practice between primary health care professionals and determined that the success of future collaboration will require health care professionals to work together at the local (micro), regional (meso) and national (macro) levels. The result of this will be better, safer and more effective health care for Australians.

Two ways to achieve collaboration are through leadership and through developing a systems-thinking approach. Firstly, health care professionals will need to demonstrate leadership qualities, which they have not necessarily been trained to do,. Secondly, looking at the primary health care system using a systems-thinking approach is an effective way to understand what it means to be a primary health care professional within a primary health care team, and to understand where each set of health care skills can be used best to benefit a the consumer.

Historically, there has been a strong focus on the GP in the provision of care within the Australian primary health care sector (Australian Institute of Health and Welfare, 2008). The role of General Practice is still likely to be crucial, and GPs will be recognised as 'gatekeepers' to services. However, the health care system of the future will require change, and for all primary health care professionals to work together collaboratively as 'networks of providers' (Australian Government Department of Ageing, 2010) to better meet the future health needs of consumers. With the increasing prevalence of chronic disease and the ageing population, primary health care professionals must work together, and practise at their full scope of practice and training as part of a collaborative primary health care team to deliver care more effectively and efficiently. This will require regular communication and clarity regarding the role of each health professional in a consumer's care journey. More broadly, this will require a shared understanding of accountability for the care of the consumer as they move between health professionals as well as shared standards relating to how care will be delivered.

Significant change is needed at the regional and local levels in order for professional collaboration to flourish. Medicare Locals provide an appropriate mechanism to support and drive collaboration; there are already good examples of local communities and Medicare Locals around Australia that are doing this. The National Primary Health Care Professional Forum provides a national leadership forum and mechanism necessary for creating and supporting policy which fosters professional collaboration, as well as to set consistent national standards of care that a consumer should expect to receive regardless of where they live. Agreement by all primary health care professions, within the National Primary Health Care Professional Forum, on the roles and responsibilities of health care professionals will provide the impetus and leverage at the regional and local levels to drive changes to professional behaviours, and ultimately to improve the coordination and quality of care provided to consumers.

The Professional Collaboration project clearly identified the positive impacts of professional collaboration on health care. This provides motivation for action. However, the absence of collaboration that was found, which can be correlated to a lack of basic standards of care and unmanaged risk – this makes immediate change necessary.

While many examples of collaborative practice exist at the local level, these are not systematic. The findings of the Professional Collaboration project suggest that to move towards a truly consumer-centred collaborative model of care, significant changes in the beliefs and attitudes of primary health care professionals will be needed.

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9.1 Specific implications for community pharmacy

A key barrier to professional collaboration for community pharmacists is that they are not always seen as primary health care professionals. Community pharmacists have the opportunity to dispel this perception by creating opportunities to collaborate in their local community of health care providers.

However, pharmacists must first move towards the 'systems' way of thinking, to think of pharmacy as a core part of the primary healthcare system and community pharmacy as a whole, rather than as individual pharmacists.. This translates to identifying a collective membership at the regional and local level that can contribute to local decision-making and initiatives and in doing so, defining:

- How local pharmacists currently contribute to care pathways

- How regional/local primary health care pharmacists will engage as a collective group with other health care providers
- What are the current and optimal local roles for pharmacists.

With national-level guidance and local-level support (as provided by Medicare Locals) for implementation of professional collaboration, community pharmacists have the potential to be an integral part of interdisciplinary collaborations (or teams) in a similar way that their hospital pharmacy colleagues have been integrated within the hospital care setting. In time, this will occur through:

- Increased contact with other professional groups which will assist in breaking down biases between groups and allow collaboration across the boundaries of established professional silos
- Improved definitions of the current and potential role of community pharmacists as part of a consumer's care journey
- Improved understanding of the collective strengths and possible contributions of each primary health care provider within a collaborative team
- Refocusing the model focused on the provider to a model that focuses on the consumer, their ease of use of the health care system and achieving optimal clinical outcomes for them.

The potential outcomes for community pharmacy from this approach are:

- Roles determined that pharmacists can play within a interdisciplinary team that will improve local population health outcomes determined by themselves
- Improved understanding and respect from their primary health care professional peers of the clinical skills they provide
- Innovation in the services provided through an interdisciplinary approach resulting from improved incentives and performance-funding mechanisms not tied to dispensing medications
- Greater professional satisfaction and support from working as part of a team of health care professionals.

As an ideal outcome, community pharmacists will be considered as part of the effective delivery of quality health care services and solutions, rather than as an adjunct service. All primary health care stakeholders will collectively define collaborative practice to recognise the role of community pharmacy in providing health care to consumers; this will also empower community pharmacists by recognising their training as health care professionals. For further progression of the professional collaboration model, it will be necessary for pharmacy as a professional group to collectively agree on their own path forward.

By establishing the roles and responsibilities of a community pharmacist when working as part of the primary health care team, community pharmacy can also set the standards of practice they wish to promote and support. This has the potential to extend the delivery of pharmacist services in primary health care outside of that of a retailer and may result in the evolution of pharmacy practice.

9.2 Recommendations

Collaboration between health care professionals in Australia is challenging but the benefits of collaboration to the Australian health care system are clear: the better delivery of effective and quality health care to the Australian consumer.

Collaboration requires the commitment of individuals and the peak body organisations that represent them. It needs to be driven from the ground up while at the same time, health care professionals and peak bodies come together to move forward a positive shared vision for primary health care.

The key recommendations for implementing the model of professional collaboration and its primary objectives are to be carried out at the same time at both the local and national level. These are:

1. The Guild should endorse and implement the model at the national governance level

The immediate next steps to progress the model of professional collaboration at the national, regional and local levels include:

a) The Guild should seek endorsement of the model by primary health care peak bodies as a means to progress professional collaboration. This cannot be achieved by one organisation; other professional peak bodies will need to endorse and support the model. The Australian Medicare Local Alliance may also be interested in helping to drive this forward.

b) Key primary health care professional bodies should start discussions about what areas to align in delivering more integrated and multidisciplinary care. This could be led by the Australian Medicare Local Alliance. The purpose of these discussions is to identify and understand agreement on policy issues. This project found that while there is disagreement on key policy issues such as the roles and responsibilities of practitioners, there is agreement in many areas – the benefits of consistent care, funding models, appropriate measures of collaboration, consumer-centred care – that if recognised and progressed could significantly improve primary health care delivery in Australia.

c) DoHA should endorse the proposed model (or a further version of this model as agreed by the relevant peak bodies), including the formation of the National Primary Health Care Professional Forum. The first activity for the forum will be to establish terms of reference and to create and endorse a charter for professional collaboration similar to that developed in the Design Forum (see Figure 28: The Australian Collaborative Healthcare Charter developed by the Professional Collaboration Design Forum). It will be important that through this process a governance and reporting path directly to DoHA be identified in order to ensure that the decisions and agreements reached by the *National Primary Health Care Professional Forum* receive due consideration. Again there may be opportunity for the Australian Medicare Local Alliance to support the administrative needs of this Forum, given its alignment with Medicare Local objectives and its current involvement in both the *National Primary Care Partnership* and the *Lead Clinicians Group*.

d) The *National Primary Health Care Professional Forum* to drive changes in training, education and clinical placements through universities – including how to work as an interdisciplinary team, and core subjects for all health professionals such as ethics, privacy and leadership.

2. *DoHA should commission an assessment of change readiness and develop a leadership program across the primary health care sector*

e) Change of this magnitude will require leadership and continuous commitment from all participants. It will also require effective change management in order to drive real and sustainable change. Similarly, the importance of readiness for change cannot be understated. Research (Armenakis et al., 1993) has shown that change initiatives will fail if participants are not motivated and ready to change. Therefore, an understanding of stakeholders' willingness and readiness to change is of key importance. While this project has demonstrated a range of stakeholder views and their readiness for change, a full assessment would provide the basis for a more detailed and strategic approach.

3. *Health professionals and consumers should drive change from the bottom-up by leveraging the infrastructure and support of Medicare Locals.*

In order to drive change at a local and regional level, health professionals and consumers at a local level should:

a) Proactively engage with their Medicare Locals to better understand their plans for integrating services in the local region. As the strategic objective of all Medicare Locals is to integrate care, professional collaboration will be a first key step on this pathway.

b) Volunteer for the Board or Advisory Committees of the Medicare Local to help shape the direction of local services. As demonstrated by the Gold Coast Medicare Local case study there are real opportunities for primary health care professionals to collectively work together to identify local health solutions and ways of working.

c) Seek information from their Medicare Locals on local population health needs (e.g. chronic disease, mental health, after-hours services) identified as a priority and the strategy for addressing them. Proposals for funding for collaborative services will be better received and supported if they align with the identified needs of the population.

d) Establish practice standards that are created and relevant at the local level, based on the nationally agreed charter and codes of collaborative practice standards. Each Medicare Local has the mandate to establish stronger clinical governance processes and collaboration should form a key part of practice standards to be upheld.

a) Identify any regional-level barriers to collaboration that can be addressed with clinician-led local solutions or low cost investments. This may include open and facilitated meetings between GPs, specialists and pharmacists in the local region seeking to improve local access, diagnostic or referral issues. The Health Pathways case study (see Section ?) is an example of how this has been demonstrated in New Zealand and Australia.

4. *Primary health care professionals should build better local relationships*

Of all the enablers to collaboration identified in the *Professional Collaboration* project, strong relationships and communication were the most significant. Based on this, all primary health care professionals should:

a) Identify opportunities to engage with health professionals in the local region. This may include face-to-face meetings with fellow health professionals and not just communicating via email or fax.

b) Reach out to other professions in the local area for opportunities to discuss collaborative initiatives that address local health issues; this may include establishing multidisciplinary groups or committees on areas of common interest, such as paediatric or diabetes special interest groups.

See Appendix F for what pharmacy can do at the local level to progress professional collaboration, see Appendix G for Medicare Locals, see Appendix H for GPs, and see Appendix I for consumer organisations.

9.3 Roadmap to implementation for the models

Figure 37 outlines an example of a roadmap to implementation for the model of professional collaboration including an overview of the proposed timeline. In the figure, R1-R4 relates to the key recommendations and K1-K80 are the relevant key findings which relate to each of the key actions.

Figure 37: Roadmap to the implementation of the model

0–6 months

- The Guild to seek endorsement of the models of professional collaboration from all peak primary health care professional bodies **(R1A)**
- The Guild to meet with key peak bodies in the first instance to understand points of alignment and further discussion on key issues **(R1B)**
- Finalise and agree on the model of professional collaboration as a key strategy to enhance professional collaboration and drive primary health care reform **(R1C)**
- DoHA endorsement of *National Primary Health Care Professional Forum* formation and provision of support agency (e.g. AMLA) **(R1C) (K1)**
- Form peak *National Primary Health Care Professional Forum* as an enhancement of the National Primary Health Care Partnership membership **(R1C) (K1)**
- DoHA to commission a change management and leadership assessment of the primary healthcare sector in order to establish a strategic approach to embedding change **(R2)**
- Local level health professionals to approach their Medicare Local regarding opportunities to support professional collaboration initiatives **(R3)** and reach out to other primary healthcare professionals in their local area to understand more about what each other do **(R4)**

Key success factors:

- Endorsement by ALL primary health care peak professional organisations
- DoHA endorsement and recognition of the *National Primary Health Care Professional Forum* as a legitimate source of advice on policy and practice.
- Consumer and provider involvement in the *National Primary Health Care Professional Forum*

6–24 months

- Define terms of reference and key objectives of the *National Primary Health Care Professional Forum* and identify reporting mechanisms upwards to DoHA and downwards (to provide and receive information to local levels) **(R1) (K1)**
- Agree key national principles for collaborative practice going forward and co-create a charter for professional collaboration behaviours to be utilised locally **(R1) (K1)**
- At the regional and local level collectively identify key barriers to collaboration for consideration and action by the *National Primary Health Care Professional Forum* e.g. policy, funding, appropriate measures etc **(R1) (K1-K5)**
- Agree and establish interim policy positions on these items and feed upward to DoHA and State Government **(K1)**
- At the national, regional and local level define and communicate scope of roles and standards of practice for collaborative primary health care between interdisciplinary teams for implementation and consistent reference **(K3-K5)**
- At the national, regional and local level define and communicate protocols for collaborative practice that can be utilised nationally. Great ideas from the local and regional level should be fed upward for national application **(R1) (R3) (K3)(K4) (K6)**
- Nationally define and communicate required skills and competencies that support collaborative primary health care practice and a related national interdisciplinary curriculum to be delivered in undergraduate and continuing education programs **(R1D) (K3)(K4) (K6)(K7)**
- Ongoing monitoring, evaluation and refinement of the model

Key success factors:

- Identifying key barriers upfront but making change happen within current policy frameworks
- Improved understanding of each other's role in care delivery
- Communication of good ideas upward to the national level and downward to local levels.

2–4 yrs

- *National Primary Health Care Professional Forum* further develop policy positions and solutions to barriers encountered in delivering collaborative care **(R1)(K1)**
- Funding models are launched that provide incentives for collaborative interdisciplinary care practices **(R1) (K2)**
- National training and education organisations deploy curriculum. Of interdisciplinary training (**R1D)(K7)**
- Regional/local level models of professional collaboration are embedded as business as usual practice with overarching clinical governance mechanisms **(R1) (R3)**
- *National Primary Health Care Professional Forum* addresses arising issues of system breakdown and lack of compliance to the agreed standards of practice by professions **(R1) (K3)**
- Development and distribution of consumer education on expectations of collaborative care arrangements **(K7)**
- *National Primary Health Care Professional Forum* assists the DoHA and State Governments in identifying and prioritising use of funding to enhance collaborative practice and population health outcomes **(K2)**
- Ongoing monitoring, evaluation and refinement of the model

Key success factors:

- Stability of the *National Primary Health Care Professional Forum* as a collaborative partnership
- Communication upwards to the *National Primary Health Care Professional Forum* and back downward to local level
- Supporting, incentivising and rewarding collaborative practice

5+yrs – Future State…

- Consumers can access appropriate interdisciplinary primary health care services that have a common plan and interact in a collaborative manner for optimal outcomes **(K1-K8)**
- The *National Primary Health Care Professional Forum* is the preferred consultation mechanism and source of expert advice from the primary health care stakeholders/experts **(K1)**
- Data and consumer information is shared collaboratively between primary health professionals reducing risk of adverse events and duplications in care **(K6)**
- Funding models support collaborative evidence based care delivery by the appropriate primary health care professionals **(K2)**
- Providers report improved professional reward from belonging to an interdisciplinary team and improved understanding of other profession's role and capabilities in efficiently improving consumer outcomes and system function. **(K5)**
- Ongoing monitoring, evaluation and refinement of the model

Key success factors:

- Collective policy positions and advice from primary health care professions
- Motivated and collaborative primary health care providers
- Improved consumer experience and outcomes
- Funding that aligns with collaborative delivery
- Optimised cost efficiency and effectiveness of the system.

Appendices

Appendix A Consultation participants

Organisation	Position
Aged and Community Services Australia	Exec Manager – Operations North, Uniting Church Homes
Arthritis Australia	CEO
Australia Association of Consultant Pharmacists	CEO
Australian College of Nurse Professionals	President
Australian College of Rural and Remote Medicine	CEO
Australian General Practice Network	Acting Exec Director Policy & Business Development
Australian Medical Association	Senior Policy Officer
Australian Pharmaceutical Healthcare Services	Managing Partner
Australian Practice Nurses Association	President
Congress of Aboriginal and Torres Strait Islander Nurses	CEO
Council Remote Area Nurses Australia	National Coordinator of Professional Services
Department of Health and Ageing	Principal Pharmacy Adviser, Pharmaceutical Benefits Division
Diabetes Australia	CEO
Diabetes VIC	CEO
Hunter New England Area Health Service	Director Pharmacy
Indigenous Allied Health Australia	President
Medicare Local – Barwon	CEO
Medicare Local – Gold Coast	CEO – Pharmacist
Medicare Local – Inner East Melbourne	CEO
Mental Health Council	CEO
National Aboriginal & Torres Strait Islander Health Worker Assoc	CEO
National Prescribing Service	CEO
National Rural Health Alliance	Exec Director
Subject matter expert, National Yang-Ming University in Taipei	President of the Pharmaceutical Society of Taiwan
Subject matter expert, Netherlands	Consultant Scientifique
Pharmaceutical Society of Australia	CEO
Community pharmacist	Pharmacist
Subject matter expert, Canada	Director Manager

Organisation	Position
Subject matter expert, NZ	Senior Associate Pharmacist
Subject matter expert, UK	Consultant
Royal Australian College of General Professionals	President – CEO
Royal College of Nursing, Australia	Director – Deputy CEO
Services for Australian Rural and Remote Allied Health	CEO
The National Preventative Health Agency	CEO
The Pharmacy Guild of Australia	Vice President, VIC branch
The Pharmacy Guild of Australia	National Director, Business Development & IT

Organisations who declined to participate in the consultations
Australian Health Practitioner Regulation Agency (AHPRA)
Allied Health Professionals Australia (AHPA)
Australian Indigenous Doctors Association (AIDA)
Consumer Health Forum of Australia (CHF)
The Society of Hospital Pharmacists Australia (SHPA)

Appendix B Consultation guide

Pharmacy Guild of Australia – Professional Collaboration Project

Consultation Guide

Background

PwC, in collaboration with the Australian General Practice Network and the Graduate School of Pharmacy, University of Technology Sydney, have been commissioned by the Pharmacy Guild of Australia to undertake a research project focussed on professional collaboration to identify a best practice model for the collaboration of community pharmacists in the primary health care setting.

This is a timely and important research project given the context of primary care reform (aimed at improving access, prevention and coordination of care), the evidence that has already been collected on the benefits of multidisciplinary care, and the need to address workforce misalignments within the health system more broadly.

The outcomes of the research will be a set of recommendations and implementation requirements for a best practice model for professional collaboration, the roles or interventions community pharmacists should engage in, and the mechanisms and enablers to achieve change.

The consultations are being undertaken across a range of stakeholder groups (e.g. pharmacy, general practice, allied health, nursing, other primary care providers, government etc). The consultations will focus on better understanding:

- Current/previous examples of multidisciplinary care
- Barriers and enablers to inter-professional collaboration
- Preferred interventions, models and mechanisms for inter-professional collaboration with community pharmacists

Thank you for agreeing to participate in the consultations, the following guide outlines some of the key areas we would like to cover with you.

We look forward to speaking with you soon.

Questions

What do existing models of inter-professional collaboration in health look like?

- What existing models and mechanisms of inter-professional collaboration in health (or more specifically, primary care) are you aware of or have been involved in?
- Which professions are involved and where are they located (ie are they co-located)?
- What are the mechanisms of communication?
- What was the evidence base or reasoning for this model of collaboration?
- What structures, policies, procedures, governance mechanisms are in place to support the model?
- Is the collaboration incentivised? What impact have these incentives had?
- How effective do you feel this model of collaboration has been? What have been the key benefits or outcomes (for both professionals and consumers)?
- What indicators are in place to measure the success of the model?

What are the barriers to inter-professional collaboration?

- Generally, what do you think are the key barriers to inter-professional collaboration in primary care?
- What are the key barriers to collaboration between community pharmacists and GPs?
- What are the key barriers to collaboration between community pharmacists and hospital pharmacists?
- What are the key barriers to collaboration between community pharmacists and other primary care providers?

Questions
What are the enablers to inter-professional collaboration?
• Generally, what do you think are the key enablers to inter-professional collaboration in primary care? • What are the key enablers to collaboration between community pharmacists and GPs? • What are the key enablers to collaboration between community pharmacists and hospital pharmacists? • What are the key enablers to collaboration between community pharmacists and other primary care providers? • How can existing structures, such as Medicare Locals, be used to better facilitate collaboration?
A model of inter-professional collaboration for community pharmacists
• What would be the preferred model and mechanisms of collaboration for community pharmacists and GPs, hospital pharmacists and other primary care providers? • What would be the key benefits of such a model? • What communication mechanisms would be required? • What resources, support systems and governance would be required to support the model? • Would incentives be required to facilitate the model? If so, what would these incentives be? • What would be the key elements required to make the model a success e.g. policies, protocols and governance? • What would be the measures of success?
Other
• Are there any other questions or anything you would like to add that has not been covered?

Appendix C Primary Health Care Professionals Survey

1 Demographic questions

Demographics of the participant

1. [ALL] Gender:

Female
Male

2. [ALL] Age:

18 and under
18 – 24
25 – 34
35 – 44
45 – 54
55 – 64
65+

The participant's profession

3. [All] Primary professional qualification:

Pharmacist (go to question 3a)
GP (go to question3b)
Nurse (go to question 3c)
Allied health professional (go to question 3d)

3a. [All Pharmacist] Are you a (please select one):

Community/Consultant Pharmacist (go to question 4)
Hospital Pharmacist (go to question 5)

3b. [GPs] Are you (please tick all that apply):

On a fixed salary
A sole owner of the general practice
A partner of the general practice

3c. [Nurse] Which best describes your position (please select one):

Disease State Educator (Asthma, Diabetes etc)
Enrolled Nurse
Midwife
Nurse Practitioner
Registered Nurse
Other (please specify)[textbox]

3d. [Allied Health] Which best describes your position (please select one):

Dentist
Dietician/ Nutritionist
Occupational Therapist
Physiotherapist
Podiatrist
Social Worker
Other (please specify)[textbox]

4. [Community and Consultant Pharmacists] Which best describes your position (please tick all that apply):

Proprietor of the pharmacy
Pharmacy Manager
Community pharmacist
Consultant/Accredited Pharmacist
Independent Consultant Pharmacist
Other (please specify)[textbox]

Location of the participants professional education

5. **Place of graduation for your primary professional qualification:**

Australia
New Zealand
Asia
UK
Europe
US
Other (please specify) [textbox]

Level of participants professional education

6. **Highest formal professional qualification you hold:**

Professional Certificate or equivalent
Bachelors degree
Masters degree
Doctorate degree
Other (please specify) [textbox]

Length of time participant has been in practice

7. **How many years have you spent practising in health care?**

0 – 5 years
6 – 10 years
11 – 15 years
16 – 20 years
21 – 25 years
26 – 30 years
31+ years

Location of participants' main workplace

8. **On average, how many hours do you work in a week?**

[Enter text]

9. **What is the postcode of the workplace where you spend the majority of your time?**

[Enter text]

10. **Please describe the workplace where you spend the majority of your time:**

Private Practice
Medical Centre
Community Health Centre
Aboriginal Medical Service
Community Aged Care Facility
Residential Aged Care Facility
Hospital
Hospital Pharmacy
Pharmacy
Private Health Insurance Facility
Other (please specify) [textbox]

11. **Please describe the area of health in which you specialise:**

Chronic Disease Management
Mental Health
Drug and Alcohol
Aged Care
Sexual Health
Health promotion/ prevention
Paediatrics/ Baby health services
Pain management
Weight management
Skincare management
Oncology
Infectious diseases
Not applicable
Other (please specify) [textbox]

12. **[FOR COMMUNITY / CONSULTANT PHARMACISTS] Please describe the location of this pharmacy (please tick all that apply):**

Isolated/ Standalone (1-9 shops together)
Medical Centre
Hospital
Neighbourhood Shopping Centre (under 30,000m²)
Regional Shopping Centre (over 100 shops or over 30,000m²)
Town or Suburb main street
City centre
Do not have a regular workplace
Other (please specify) [textbox]

[FOR GPS, NURSES, ALLIED HEALTH CARE AND HOSPITAL PHARMACISTS] Please describe the location of this workplace (please tick all that apply):

Isolated/ Standalone (1-9 shops together)
Medical Centre
Hospital
Neighbourhood Shopping Centre (under 30,000m²)
Regional Shopping Centre (over 100 shops or over 30,000m²)
Town or Suburb main street
City centre
Do not have a regular workplace
Other (please specify) [textbox]

Type of ownership of pharmacy

13. **[FOR COMMUNITY / CONSULTANT PHARMACISTS ONLY] Is this pharmacy in a banner group?**

Yes
No
Not sure

[FOR GPS, NURSES, ALLIED HEALTH CARE AND HOSPITAL PHARMACISTS] Is this workplace:

Solely owned
Owned by a partnership
Corporately owned
Government run
Other [Enter Text]
Not sure

Design of the pharmacy

14. **[FOR COMMUNITY / CONSULTANT PHARMACISTS] Does this pharmacy have a designated professional service area? (i.e. Counselling/ Consulting area, Dispensary, S2- Pharmacy Medicines or S3, Pharmacists Only Medicines)**

Yes.
No

Proximity to community pharmacists/ other health professionals

15. **[FOR COMMUNITY / CONSULTANT PHARMACISTS] Please indicate whether your primary place of work employs or invites any of the following health professionals to operate from within its premises:**

	Daily	Weekly	Monthly	Every few months	Never	Not sure
Dentist	□	□	□	□	□	□
Dietician/ Nutritionist	□	□	□	□	□	□
GPs	□	□	□	□	□	□
Hospital Pharmacist	□	□	□	□	□	□
Nurses	□	□	□	□	□	□
Occupational Therapist	□	□	□	□	□	□
Physiotherapist	□	□	□	□	□	□
Podiatrist	□	□	□	□	□	□
Social Worker	□	□	□	□	□	□
Other (please specify)	□	□	□	□	□	□

16. **[FOR COMMUNITY / CONSULTANT PHARMACISTS] In regards to the other health care professionals with whom you have most dealings, which of the following best describes the location of their workplace?**

In the same shopping complex or building
Next door to one another
Less than 10 minutes walk away
Within a 1 hour drive
More than 1 hours drive away
Other (please specify)[textbox]

[FOR GPS, NURSES, ALLIED HEALTH CARE AND HOSPITAL PHARMACISTS] In regards to the community pharmacist with whom you have most dealings, which of the following best describes the location of their pharmacy from your workplace?

In the same shopping complex or building
Next door to one another
Less than 10 minutes walk away
Within a 1 hour drive
More than 1 hours drive away
Other (please specify)[textbox]

17. ****[FOR COMMUNITY / CONSULTANT PHARMACISTS] Does your place of work employ/ contract an accredited pharmacist to perform Medication Management Reviews?**

Yes
No

2 To what extent are primary health care professionals collaborating?

The following definition of interprofessional collaboration is by the World Health Organisation (2010) and was identified through a literature review undertaken as part of this project. :

Collaborative practice in health occur when multiple health workers provide comprehensive services by working together synergistically along with patients, their families, carers and communities to deliver the highest quality care across settings (World Health Organisation, 2010).

This definition of collaboration will be used throughout the remainder of this survey as a common basis of understanding.

18. [ALL] With this definition in mind, how often do you collaborate with the following professions?

Profession	Daily	Weekly	Fortnightly	Monthly	Every 6 months	Yearly	Never	Not sure
GP	□	□	□	□	□	□	□	□
Nurse	□	□	□	□	□	□	□	□
Pharmacist	□	□	□	□	□	□	□	□
Allied Health	□	□	□	□	□	□	□	□

19. [ALL] How would you rank the following on working collaboratively with other health care professionals?

	Highly collaborative	Often collaborative	Collaborative	Sometimes collaborative	Not at all collaborative	Not sure
a) Your workplace (where you spend most of your time)	□	□	□	□	□	□
b) Yourself	□	□	□	□	□	□

20. [ALL] Please provide any additional comments/experiences you have on collaboration

[textbox]

3 What are primary health care professionals' preferred mode of communication (e.g. email, phone)

Communication is an important component of collaboration, in this section we are interested in how you prefer to interact with other health care professionals

Communication –tools and methods

21. [FOR COMMUNITY / CONSULTANT PHARMACISTS] How do you prefer to contact (Please select your top 3 methods):

a. A GP?

Mail
Email
Phone
Videoconference
Fax
Face to Face
Other (please specify) [textbox]
I do not contact them

b. A nurse?

Mail
Email
Phone
Videoconference
Fax
Face to Face
Other (please specify) [textbox]
I do not contact them

c. An allied health professional?

Mail
Email
Phone
Videoconference
Fax
Face to Face
Other (please specify) [textbox]
I do not contact them

d. A hospital pharmacist?

Mail
Email
Phone
Videoconference
Fax
Face to Face
Other (please specify) [textbox]
I do not contact them

[FOR GPS, NURSES, ALLIED HEALTH CARE PROFESSIONALS AND HOSPITAL PHARMACISTS] How do you prefer to contact a community pharmacist? (Please select your top 3 methods)

Mail
Email
Phone
Videoconference
Fax
Face to Face
Other (please specify) [textbox]
I do not contact them

22. **[FOR COMMUNITY / CONSULTANT PHARMACISTS] How do you prefer to be contacted by (Please select your top 3 methods):**

a. **A GP?**

Mail
Email
Phone
Videoconference
Fax
Face to Face
Other (please specify) [textbox]
Not at all

b. **A nurse?**

Mail
Email
Phone
Videoconference
Fax
Face to Face
Other (please specify) [textbox]
Not at all

c. **An allied health professional?**

Mail
Email
Phone
Videoconference
Fax
Face to Face
Other (please specify) [textbox]
Not at all

d. **A hospital pharmacist?**

Mail
Email
Phone
Videoconference
Fax
Face to Face
Other (please specify) [textbox]
Not at all

[FOR GPS, NURSES, ALLIED HEALTH CARE PROFESSIONALS AND HOSPITAL PHARMACISTS] How do you prefer to be contacted by a community pharmacist? (Please select your top 3 methods)

Mail
Email
Phone
Videoconference
Fax
Face to Face
Other (please specify) [textbox]
They do not contact me

4 What do primary health care professionals see as the benefits of professional collaboration?

Experience of collaboration

23. **[FOR COMMUNITY / CONSULTANT PHARMACISTS] How do you find the experience of working collaboratively with other health care professionals?**

- Very beneficial
- Beneficial
- Neither beneficial or not beneficial
- Not very beneficial
- Not beneficial at all
- Not applicable

[FOR GPS, NURSES, ALLIED HEALTH CARE AND HOSPITAL PHARMACISTS] How do you find the experience of working collaboratively with community pharmacists?

- Very beneficial
- Beneficial
- Neither beneficial or not beneficial
- Not very beneficial
- Not beneficial at all
- Not applicable

Benefits of collaboration

24. **[ALL]What do you see as the specific consumer benefits of collaboration (please rank in order of your top 5 preferences, with 1 being most important)?**

- Improved quality of care for consumers
- Reduced mortality for consumers
- Fewer clinic visits and hospital stays for consumers
- Higher levels of consumer satisfaction with care outcomes
- Better consumer acceptance of care
- Enhanced patient safety for consumers
- Reduced medical errors for consumers through better communication
- Clarification of the nature of consumer problems
- Other (please specify) [textbox]

25. **[ALL] What do you see as the specific professional benefits of collaboration (please rank in order of your top 5 preferences, with 1 being most important)?**

- Greater collaborative decision making with health professionals
- Increased job satisfaction for the health professional
- Reduced workload issues for the health professional
- Increased staff motivation for the health professional
- Reduced staff turnover for the health professional
- Innovative practices for the health professional
- Other (please specify) [textbox]

26. [ALL] What do you see as the specific organisational or health system benefits of collaboration (please rank in order of your top 5 preferences, with 1 being most important)?

Decreased costs associated with hospitalisation for the organisation
Lower hospitalisation admission rates for the organisation
Reduced physician visits for the organisation
Reduced costs for the organisation
Increased financial reward for the organisation
Reduced length of hospital stay for the organisation
Reduced service duplication for the organisation
Greater continuity and coordination of care for the organisation
More frequent and appropriate referral patterns for the organisation
Other (please specify) [textbox]

27. [ALL] Of three types of benefits of collaboration listed in the question above (consumer, professional and organisational benefits), please rank these in terms of importance to you, with 1 being most important

28. [ALL] Please provide any additional comments/views you have on the benefits of collaboration

[textbox]

5 What are the enablers and barriers to collaboration for health care professionals?

Experience of enablers of collaboration

29. [FOR COMMUNITY / CONSULTANT PHARMACISTS] In your experience, which have you found to be the most important enablers of working with other primary health care professionals? Please rank in order of your top 5 preferences, with 1 being most important.

- Legislation and policies
- Organisational structures and mechanisms
- Leadership
- Funding
- Location and infrastructure
- Technology
- Communication
- Building relationships
- Other (please specify)

[FOR GPS, NURSES, ALLIED HEALTH CARE AND HOSPITAL PHARMACISTS] In your experience, which have you found to be the most important enablers of working with community /consultant pharmacists? Please rank in order of your top 5 preferences, with 1 being most important.

- Legislation and policies
- Organisational structures and mechanisms
- Leadership
- Funding
- Location and infrastructure
- Technology
- Communication
- Building relationships
- Other (please specify)

Experience of barriers of collaboration

30. [FOR COMMUNITY / CONSULTANT PHARMACISTS] In your experience, which have you found to be the key barriers of working with other primary health care professionals? Please rank in order of your top 5 preferences, with 1 being most important.

- Legislation and policies
- Organisational structures and mechanisms
- Leadership
- Funding
- Infrastructure and location
- Technology
- Communication
- Building relationships
- Other (please specify)

[FOR GPS, NURSES, ALLIED HEALTH CARE AND HOSPITAL PHARMACISTS] In your experience, which have you found to be the key barriers of working with community /consultant pharmacists? Please rank in order of your top 5 preferences, with 1 being most important.

- Legislation and policies
- Organisational structures and mechanisms
- Leadership
- Funding
- Infrastructure and location
- Technology
- Communication
- Building relationships
- Other (please specify)

31. [ALL] In your experience, what have you found to be effective methods of overcoming the barriers you ranked above?

[Enter text]

32. [ALL] Do you have any further comments on enablers and barriers to collaboration?

[Enter text]

6 *What are primary health care professionals' current attitudes and behaviours towards collaboration, in particular their levels of readiness and willingness to collaborate? And what levels of support, resources and education are required to support collaboration?*

33. [ALL] Please indicate the extent to which you disagree or agree with the following?

(SD – strongly disagree, D – disagree, N – neither agree nor disagree, A – agree, SA – strongly agree).

	SD	D	N	A	SA	NA
Change self-efficacy						
My past experiences makes me confident that I will be able to collaborate successfully with community pharmacists/other health care professionals in the future	☐	☐	☐	☐	☐	☐
I have the skills required to collaborate effectively with community pharmacists/other health care professionals	☐	☐	☐	☐	☐	☐
I am intimidated by all the new skills (e.g. networking with other health care professionals) I have to learn to work collaboratively with community pharmacists/other health care professionals	☐	☐	☐	☐	☐	☐
I do not anticipate any problems adjusting to new ways of working if I have to work collaboratively with community pharmacists/other health care professionals in the future	☐	☐	☐	☐	☐	☐
Need for change						
There are legitimate and rational reasons to work collaboratively with community pharmacists/other health care professionals in delivering patient care	☐	☐	☐	☐	☐	☐
I want to work collaboratively with community pharmacists/other health care professionals	☐	☐	☐	☐	☐	☐
Working collaboratively with community pharmacists/other health care professionals is a clearly needed change in the future	☐	☐	☐	☐	☐	☐
The time spent of working collaboratively with community pharmacists/other health care professionals could be better spent working on something else	☐	☐	☐	☐	☐	☐
I am willing to work with community pharmacists/other health care professionals	☐	☐	☐	☐	☐	☐
I feel that community pharmacists/other health care professionals are willing to work with me	☐	☐	☐	☐	☐	☐
Personal benefits of change						
I can see working collaboratively with community pharmacists/other health care professionals will have financial benefits for myself	☐	☐	☐	☐	☐	☐
Collaborating with community pharmacists/other health care professionals is time consuming and will disrupt the way I do things around here	☐	☐	☐	☐	☐	☐
I am worried I will lose some of my professional status if I were to collaborate with community pharmacists/other health care professionals	☐	☐	☐	☐	☐	☐
Working collaboratively with community pharmacists/other health care professionals makes/ will make my job easier	☐	☐	☐	☐	☐	☐
The effort required to collaborate with community pharmacists/other health care professionals is small compared to the benefits I see coming from it	☐	☐	☐	☐	☐	☐
Relationships						

	SD	D	N	A	SA	NA
I respect and value the contribution of community pharmacists/other health care professionals	□	□	□	□	□	□
I do not trust the professional judgment of community pharmacists/other health care professionals and hesitate to take onboard their advice	□	□	□	□	□	□
I do not understand the roles and responsibilities of community pharmacists/other health care professionals in a team environment	□	□	□	□	□	□
Information and sharing						
Technology like video conferencing and e-records make it easy for me to share consumer information and collaborate with community pharmacists/other health care professionals	□	□	□	□	□	□
I am willing to share consumer information with community pharmacists/other health care professionals	□	□	□	□	□	□
Professional development and education						
I received sufficient training in ways of working with community pharmacists/other health care professionals	□	□	□	□	□	□
I think that current higher education like TAFE and university equips me with the skills to work collaboratively with community pharmacists/other health care professionals	□	□	□	□	□	□
I would benefit from continuing professional development in the areas of collaboration	□	□	□	□	□	□
Organisational benefits						
I think my organisation will benefit from collaborating with community pharmacists/other health care professionals	□	□	□	□	□	□
When we work collaboratively with community pharmacists/other health care professionals, we can better meet consumer needs	□	□	□	□	□	□
Collaborating with community pharmacists/other health care professionals matches the priorities of my organisation	□	□	□	□	□	□
Support of management						
My organisation has done a great job in facilitating working collaboratively with community pharmacists/other health care professionals in the past	□	□	□	□	□	□
Champions and leaders in my organisation serve as a role model and encourage for working collaboratively with community pharmacists/other health care professionals	□	□	□	□	□	□
Our organisation provides resources such as staffing to support collaborative working	□	□	□	□	□	□
I am convinced that the organisation's senior management is committed to working collaboratively with other health care professionals in the future	□	□	□	□	□	□
I think any time spent on collaborating with community pharmacists/other health care professionals will be wasted given that legislation and policies don't support this	□	□	□	□	□	□

34. Please include any other comments you have regarding interprofessional collaboration

[Textbox]

Appendix D Survey sample weighting

Table 23: Distribution of sample after weighting

Survey data (unweighted)

	Major cities	Regional to very remote	All regions
Pharmacists	595	333	928
	20.4%	11.4%	31.8%
GPS	310	129	439
	10.6%	4.4%	15.0%
Nurses	469	337	806
	16.1%	11.5%	27.6%
Allied health	452	296	748
	15.5%	10.1%	25.6%
All professions	1,826	1,095	2,921
	62.5%	37.5%	100.0%

2006 ABS data

	Major cities	Regional to very remote	All regions
Pharmacists	12,888	4,445	17,333
	8.2%	2.8%	11.0%
GPS	23,125	6,756	29,881
	14.6%	4.3%	18.9%
Nurses	28,748	16,793	45,541
	18.2%	10.6%	28.8%
Allied health	50,157	15,024	65,181
	31.8%	9.5%	41.3%
All professions	114,918	43,018	157,936
	72.8%	27.2%	100.0%

Survey data (weighted)

	Major cities	Regional to very remote	All regions
Pharmacists	238	82	321
	8.2%	2.8%	11.0%
GPS	428	125	553
	14.6%	4.3%	18.9%
Nurses	532	311	842
	18.2%	10.6%	28.8%
Allied health	928	278	1,206
	31.8%	9.5%	41.3%
All professions	2,125	796	2,921
	72.8%	27.2%	100.0%

Appendix E Measures

NHPA Initial indicators for Medicare Locals

As the Medicare Locals will be newly established independent corporations a large number of indicators will require data development work and it is envisaged that the indicators below will be introduced progressively over time. However, some primary care data is already collected, including through the Divisions of General Practice's National Performance Indicators framework.

Note: All indicators for Medicare Locals will be reported by Indigenous and non-Indigenous status where statistically possible

1 Effectiveness – Safety and quality

1.1 Selected potentially avoidable hospitalisations;

1.2 Percentage of diabetic patients who have a GP annual cycle of care;

1.3 Percentage of asthma patients with a written asthma plan;

1.4 Aged standardised mortality of potentially avoidable deaths; and

1.5 Five year survival proportions of selected cancers.

2 Effectiveness – Patient experience

2.1 Measures of patient experience.

3 Equity and effectiveness – Access

3.1 Access to services by type of service compared to need;

3.2 GP type service use;

3.3 Allied health type service use;

3.4 Specialist service utilisation;

3.5 Waiting times for GP services;

3.6 Waiting times for community health services;

3.7 Screening rates for breast, cervical and bowel cancer;

3.8 Vaccination rates for children;

3.9 GP service utilisation by residents of Residential Aged Care Facilities;

3.10 Proportion of children with three year old developmental health check;

3.11 Number of women with at least one antenatal visit in the first trimester;

3.12 After hours GP service utilisation;

3.13 Primary care-type Emergency Department attendances;

3.14 Percentage of the population receiving primary mental health care; and

3.15 Rates of contact with primary mental health care by children and young people.

4 Efficiency – Financial performance

4.1 Financial performance against budget.

Note: further financial indicators to be developed by the Authority.

5 Population health outcome measures: included in healthy communities reports to provide context for the interpretation of Medicare Local performance indicators

Note: Initially these measures are expected to provide contextual and planning information for Medicare Locals. Over the long term, and as the Framework and measures become more sophisticated, relative changes in these measures may be used to assess Medicare Local performance.

5.1 Incidence of selected cancers;

5.2 Incidence of ischaemic heart disease;

5.3 Prevalence of diabetes;

5.4 Prevalence of smoking;

5.5 Prevalence of overweight and obese status;

5.6 Incidence of end stage kidney disease;

5.7 Estimated life expectancies at birth;

5.8 Infant/young child mortality rate; and

5.9 Proportion of babies born with low birth weight.

Appendix F What community pharmacy can do to contribute to professional collaboration

Currently, health professionals are working in 'silos', operating in isolation from each other without sharing processes or information. To improve outcomes for consumers, they need to start working collaboratively in order to deliver better and more effective care. Lack of collaboration has been linked to negative consumer outcomes such as adverse drug events and avoidable hospital admissions. Conversely, the case for collaboration is strong with a wide range of benefits identified for consumers, health professionals, health services and the overall health care system.

Through the professional collaboration model, community pharmacy can play a larger role in providing primary care to consumers, given their accessibility and in-depth knowledge of medicines. This document outlines the findings from research undertaken as part of the *Professional Collaboration* project. It describes some next steps to implementing this recommended model that will result in immediate benefits.

Research finding and recommendation	What community pharmacy can do next
1. *Health professionals can work collaboratively through their Medical Local*	Community pharmacy can use their Medicare Locals as a starting point to work collaboratively by: • Actively participating on the boards/subcommittees of Medicare Locals in their local areas to represent the pharmacy profession. • Actively participating in Medicare Local initiatives such as Local Community Partnerships and Health Pathways which are multidisciplinary teams formed to access Medicare Local flexible funding, focused on developing innovative and sustainable models of collaborative care based on local health needs. • Through these initiatives, developing shared policies, procedures and processes at the local level. This could include agreement on assessment, referral, eligibility, shared care plans and care pathways. • Working with Medicare Locals to ensure that their information in the National Health Service Directory is kept up to date to facilitate improved access to their services for both health care professionals and consumers
2. *Building and strengthening relationships with other primary health care professionals*	The most important factor that enables collaboration as identified by primary health professionals themselves is building strong working relationships over time. Community pharmacy can achieve this by: • Introducing themselves to other local GPs or allied health professionals used by their regular consumers through a letter of introduction. • Following up the introduction letter with a phone call to arrange to meet with the other health professional in person - with the purpose of establishing a local network of primary health care providers for improving collaborative care. • Networking regularly with groups of health professionals through video or teleconference, or in person, to discuss local needs and how to work together collaboratively. • Through these networking meetings, sharing useful information and planning for better collaboration. This could include sharing decisions on referral pathways, identifying future shared activities, linking with Medical Local initiatives, developing conflict resolution and escalation guidelines and processes, and identifying how to involve other local health care professionals. • Strengthening collaborative relationships between health care professionals by an agreed and organised strategic process including understanding each other's roles, respecting each other's viewpoints, establishing common goals that focus on the health and well-being of consumers, creating accountability for those goals and sharing information where possible.

Research finding and recommendation	What community pharmacy can do next
	• Actively seeing every consultation as an opportunity to improve patient outcomes, and therefore referring consumers to relevant health professionals when appropriate or escalating concerns by phone, which is the preferred method of communication identified by health professionals. • Seeking and providing feedback to other health care professionals at the time of each interaction to ensure that all concerns and issues are addressed.
3. *Health professionals feel they require more training on collaborative skills*	Strong leadership to advocate for and champion professional collaboration is required at every level. In the case of primary health care, strong leadership is required at the grassroots level from health care professionals. Community pharmacy (and pharmacists) can achieve this by: • Regularly attending interdisciplinary training provided by Medicare Locals and the Pharmaceutical Society of Australia[28]. The aim of this training is to better equip all health professionals with the core skills and competencies to work collaboratively. • Through training, developing key skills such as communication, conflict resolution, setting shared goals and decision-making. The training will also provide a good opportunity for health care professionals to understand the roles and scope of practice of others. • Identifying and working with Medicare Locals on the shared policies, procedures and processes that are required to work collaboratively. • Assessing their teams' current effectiveness of collaboration by using a tool to identify areas of strengths and improvement. An example of a tool to measure short-term effectiveness was developed by the Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative in Canada.
4. *Leadership is required at all levels in order for collaboration to become systemic and normal practice.*	One of the more difficult barriers to changing current practice is how to sustain momentum. This can be overcome through strong leadership that advocates for and champions professional collaboration at every level. In the case of primary health care, strong leadership is required from health care professionals. Community pharmacy can achieve this by: • Advocating for and championing professional collaboration to colleagues and in particular, highlighting how it drives better health outcomes by addressing the needs of consumers. • Developing and encouraging a culture of collaboration in their workplace. • Advocating to their peak bodies to drive professional collaboration. • Actively participating in Medicare Local boards and initiatives, representing the pharmacy profession in their area.
5. *There is little data being collected on collaboration making it difficult to evaluate its effectiveness*	Community pharmacy can contribute to the evidence base for collaboration that is needed to evaluate collaborative practices in the future. Community pharmacy (and pharmacists) can achieve this by: • Meeting the minimum requirements to be set by the National Health Performance Authority to evaluate consumers' use and experiences of primary health care. • Starting to document collaborative practices achieved in Medicare Local initiatives, local networking with health professionals, medicines reviews, chronic disease management programs and other areas. • Undertaking a survey of consumers to measure their satisfaction with the current level of professional collaboration, what collaborative services they value and what future services are desired.

[28] The Pharmaceutical Society of Australia and the Royal Australian College of General Practitioners have signed a second Memorandum of Understanding to further strengthen collaborative efforts between the two organisations. The framework looks at ways of working together to improve patient health outcomes in the context of primary healthcare and will be focused on policy development, education and training, media management and advocacy.

Appendix G What Medicare Locals can do to contribute to professional collaboration

Medicare Locals play an important role in the implementation of the model of professional collaboration. This document outlines the findings from research undertaken as part of the *Professional Collaboration* project. It describes some next steps to implementing this recommended model that will result in immediate benefits.

	Research finding and recommendation	What Medicare Locals can do next
1	*Health professionals are currently operating in silos and need to work collaboratively in order to deliver better and more effective care to improve consumer health outcomes*	Medicare Locals have the key aim of establishing effective collaborations and supporting greater linkages in primary health care in their local area. They can foster professional collaboration through: • Analysing and understanding local health needs, and then identifying where collaboration can meet these needs and how Medicare Locals can support this. • Developing strategic plans and a whole-of-systems approach to primary care based on these needs. • Establishing and supporting initiatives such as Local Community Partnerships that deliver multidisciplinary coordinated and integrated care, and encouraging participation in them by local health professionals. • Supporting local collaborative initiatives which can be facilitated by an Integration Manager who can also provide oversight and project management. • Partnering with Local Health Networks to broker the relationship between the acute/sub-acute and primary health care professionals who drive changes in the health care system. • Leveraging off any available Local Health Network resources for working collaboratively.
2	*Fee-for-service funding does not encourage collaboration and future funding approaches needs to circumvent this barrier*	Medicare Locals receive funding to deliver certain programs, such as after-hours primary care services, as well as flexible funding to meet specific local health needs. They can foster professional collaboration through: • Encouraging health professionals to apply for funding for and develop innovative and sustainable models of working collaboratively to deliver care. • Testing and validating funding models to see which is most effective for enabling collaboration between health professionals. • Distributing funding equitably to all health professionals involved and ensuring a transparent and fair funding process.
3	*Currently, there is no standardised set of performance measures for collaboration; success needs to be defined at a local level to evaluate future efforts*	Medicare Locals will be evaluated against current and future key performance indicators set by the National Health Performance Authority. Currently, these indicators relate to the use of, and experiences with, primary health care (mostly for GP or GP after-hours services). Medicare Locals can foster professional collaboration through: • Advocating for these key performance indicators to be extended to other primary health care professions outside of General Practice and for the indicators to measure the entire care journey, and not just a single episode of care provided by a GP. • Defining and shaping what success is based on specific local health needs. • Determining the indicators to measure the performance of future collaborative efforts with a key focus on collaborative behaviours. • Developing a definition of 'collaboration' that is locally relevant.

Research finding and recommendation		What Medicare Locals can do next
4	*Not all health professionals understand the benefits of collaboration or feel that more adequate and further training is required*	Medicare Locals will play a key role in building the capacity of primary health care organisations. They can foster professional collaboration through: • Providing practice support to primary health care services including general practice, allied health services and community pharmacy by assisting with staff training and providing resources to primary health care professionals for working collaboratively, including information on best practice and case studies of collaborative models. • Developing and delivering training on core collaborative skills, as well as facilitating interdisciplinary learning in the local area. • Developing communication guidelines for local health care professionals including on engaging with other health care professionals, communication styles and providing feedback. • Advocating on the benefits of collaboration to Government, based on the evidence base collected through the experiences of Medicare Locals.

Appendix H What GPs can do to contribute to professional collaboration

Currently, health professionals are working in 'silos', operating in isolation from each other without sharing processes or information. To improve outcomes for consumers, they need to start working collaboratively in order to deliver better and more effective care. Lack of collaboration has been linked to negative consumer outcomes such as adverse drug events and avoidable hospital admissions. Conversely, the case for collaboration is strong with a wide range of benefits identified for consumers, health professionals, health services and the overall health care system.

General Practitioners (GPs) are the common link in primary care between consumers (and carers) and other health care professionals and play a key role in the success of professional collaboration efforts. This document outlines the findings from research undertaken as part of the *Professional Collaboration* project. It describes some next steps to implementing this recommended model that will result in immediate benefits.

Research finding and recommendation	What GPs can do next
1. *Health professionals can work collaboratively through their Medical Local*	GPs can use their Medicare Local as another starting point to work collaboratively by: • Actively participating in Medicare Local initiatives such as Local Community Partnerships and Health Pathways which are multidisciplinary teams formed to access Medicare Local flexible funding, focused on developing innovative and sustainable models of collaborative care based on local health needs. • Through these initiatives, developing shared policies, procedures and processes at the local level. This could include agreement on assessment, referral, eligibility, shared care plans and care pathways. • Actively participating on the boards of Medicare Locals in their local areas representing general practice. • Working with Medicare Locals to ensure that their information in the National Health Service Directory is kept up to date to facilitate improved access to their services for both health care professionals and consumers.
2. *Building and strengthening relationships with other primary health care professionals*	The most important factor that enables collaboration as identified by primary health professionals themselves is building strong working relationships over time. GPs can achieve this by: • Introducing themselves to local pharmacists or allied health professionals used by their regular patients through a letter of introduction. • Following up the letter of introduction with a phone call to arrange to meet the health professional in person, with the purpose of establishing a local network of primary health care providers for improving collaborative care. • Networking regularly with groups of health professionals through video or teleconference, or in person, to discuss local needs and how to work together collaboratively. • Through these networking meetings, sharing useful information and planning for better collaboration. This could include sharing decisions on referral pathways, identifying future shared activities, linking with Medical Local initiatives, developing conflict resolution and escalation guidelines and processes, and identifying how to involve other local health care professionals. • Strengthening collaborative relationships between health care professionals by an agreed and organised strategic process including understanding each other's roles, respecting each other's viewpoints, establishing common goals that focus on the health and well-being of consumers, creating accountability for those goals and sharing information where possible. • Actively seeing every consultation as an opportunity to improve patient outcomes, and

Research finding and recommendation		What GPs can do next
		therefore referring consumers to relevant health professionals when appropriate or escalating concerns by phone, which is the preferred method of communication identified by health professionals. • Seeking and providing feedback to other health care professionals at the time of each interaction to ensure that all concerns and issues are addressed
3.	*Health professionals feel they require more training on collaborative skills*	GPs can utilise training and resources provided by their Medicare Locals and the Royal Australian College of General Practitioners to further develop skills and competencies to work collaboratively. GPs can achieve this by: • Regularly attending interdisciplinary training provided by Medicare Locals and the Royal Australian College of General Practitioners. The aim of this training is to better equip all health professionals with the core skills and competencies to work collaboratively. • Through training, developing key skills such as communication, conflict resolution, setting shared goals and decision-making. The training will also provide a good opportunity for health care professionals to understand the roles and scope of practice of others. • Identifying and working with Medicare Locals on the shared policies, procedures and processes that are required to work collaboratively. • Assessing their teams' current effectiveness of collaboration by using a tool to identify areas of strengths and improvement. An example of a tool to measure short-term effectiveness was developed by the Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative in Canada.
4.	*Leadership is required at all levels in order for collaboration to become systemic and normal practice*	Strong leadership, to advocate for and champion professional collaboration, is required at every level of health care. In the case of primary health care, strong grassroots leadership is required from health care professionals. GPs can contribute to this by: • Advocating for and championing professional collaboration to colleagues and in particular, highlighting how it drives better health outcomes by addressing the needs of consumers. • Developing and encouraging a culture of collaboration in their workplace. • Advocating to their peak bodies to drive professional collaboration. • Actively participating in Medicare Local boards and initiatives, representing general practice in their area.
5.	*There is little data being collected on collaboration making it difficult to evaluate its effectiveness*	General Practice can contribute to the evidence base for collaboration that is needed to evaluate collaborative practices in the future. GPs can achieve this by: • Meeting the minimum requirements to be set by the National Health Performance Authority to evaluate consumers' use and experiences of primary health care. • Starting to document collaborative practices achieved in Medicare Local initiatives, local networking with health professionals, medicines reviews, chronic disease management programs and other areas. • Undertaking a survey of consumers to measure their satisfaction with the current level of professional collaboration, what collaborative services they value and what future services are desired.

Appendix I What consumer organisations can do to contribute to professional collaboration

Primary health care in Australia is moving towards a consumer-centred model: one that places at its centre an active and empowered consumer – and carer – who can easily access quality and timely care. It means that health care is based on the needs of the consumer and not on the service or system. Quality care involves all health professionals working collaboratively to ensure its seamless delivery. The benefits of this professional collaboration to the consumer are great: improved quality, safety and better health outcomes. It is also important in this model for the consumer to be engaged in their health care and to improve their general health literacy to allow for better navigation through the health system. This document outlines the findings from research undertaken as part of the *Professional Collaboration* project. It describes some next steps to implementing this recommended model that will result in immediate benefits.

	Research finding and recommendation	What consumer organisations can do next
1	*There is a lack of strategic vision of professional collaboration at a national level and endorsement of it is required by consumer health organisations*	Consumers (and carers), through the Consumers Health Forum of Australia (CHF) and other consumer health organisations are well placed to contribute to the development of a national strategy on collaborative care by: • Driving the national agenda for and shaping the model of professional collaboration by actively pursuing opportunities to consult with Government, peak bodies and other stakeholders about the issue. • Advocating for its importance to Government through the development of a discussion or position paper highlighting the benefits of professional collaboration to consumers and the need for it to improve health outcomes and care delivery. • Participating in the development of a nationally consistent definition of collaboration including the central role of the consumer in the model of care. • Participating in refining future key performance indicators set by the National Health Performance Authority to extend to primary health care professions outside of General Practice. • Participating with peak bodies and Medicare Locals in the development of a training curriculum for collaborative working skills for health professionals, ensuring that it reflects the needs of the consumer. • Through peak bodies and other organisations, developing and delivering training and resources to consumers on what to expect from and the importance of collaborative practices in primary care.
2	*Effective leadership and support for professional collaboration is required at all levels in the primary health care system including consumers*	Individual consumers (and carers) can also play an important part in supporting professional collaboration at the regional and local level by: • Identifying, through CHF and other consumer health organisations, consumers willing to participate and consult with Medical Locals as part of community and consumer advisory boards. • Linking, through Medicare Locals, to networks of local health care providers to provide consumer perspectives when making decisions about local policies, processes and procedures. • Advocating to other consumers about the benefits and need for professional collaboration, and raising awareness and gaining support for the issue.
3	*Consumers should feel empowered to take an active role in their health care*	Individual consumers (and carers) should feel empowered and informed to take an active role in their health care, and feel confident in navigating the system and accessing timely and quality services. They can achieve this by: • Participating in training and using resources delivered by the CHF and other consumer health organisations to understand what they can expect from a collaborative model of care.

Research finding and recommendation	What consumer organisations can do next
	• Signing up for the personally controlled electronic health record (PCEHR) so there is one source of information for the consumer's health history, medications and services received. • Understanding their rights as consumers and the ethical and legal obligations of the health care professionals that are delivering their care. • Be proactive in asking questions where they need clarification on health services including services received or needed and about their overall care.

Appendix J Bibliography

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