Refreshing the blueprint: a supplement to *Healthy people, Healthy systems*

Enabling person-centred, team-based care

KEY ACTION AREAS

ahha
australian healthcare & hospitals association
the voice of public healthcare®

OCTOBER 2020

Enabling person-centred, team-based care

ACHIEVING HEALTH AND WELL-BEING

A person's health and well-being is dependent on the interplay of complex relationships between biological, lifestyle, socioeconomic, societal and environmental factors (AIHW 2016). Enjoying the highest attainable standard of health is a human right, but the conditions for doing so are well-known to be inequitably distributed (AIHW 2016). Practically recognising and responding to these factors and conditions in health care needs to be a priority (Farre & Rapley 2017).

Health care is inherently interdependent and increasingly complex (Rosen et al. 2018). Medical knowledge is expanding exponentially, with the volume estimated to be doubling every 50 years in 1950, to doubling every 73 days in 2020 (Densen 2011). Staying current across the breadth of information is an increasing challenge for any individual.

With aging populations and an increasing prevalence of multimorbidity, a shift from a single disease focus is needed (Harrison et al. 2016) and priority setting is critical (Harris et al. 2013). The value from embedding non-clinical support in the provision of health care (such as social prescribing and mental health support) is well-recognised (e.g., CHF 2019; Black Dog Institute 2019) and an important preventive health strategy.

The need for integrated, team-based models of care has been promoted for decades (Farre & Rapley 2017), yet the system is still facing challenges in operationalising such models.

> "The need for integrated, team-based models of care has been promoted for decades, yet the system is still facing challenges in operationalising such models"

PERSON-CENTRED TEAM-BASED CARE

Person-centred care is care that is respectful of, and responsive to, the preferences needs and values of the individual (ACSQHC 2011). Team-based care occurs when care providers work together with a shared focus centred on a person's needs and with collective ownership of the goals to be achieved.

Teams may encompass members from both clinical and non-clinical disciplines, across various settings, including acute and primary care, as well as settings broader than just health care. Providers may be from the public, private or not-for-profit sectors, functioning under one organisational umbrella or drawn from a range of organisations. Distinctly, however, teams see themselves, and are seen by others, as an intact social entity (Cohen & Bailey 1997). In the context of patient care, they are identifiable and cohesive in their relationship with the patient, their family and carers, who themselves are critical, active members of the team.

Teams can also be dynamic. As a patient's condition changes over time, the composition of the team may change to reflect shifting clinical and psychosocial needs (Mitchell et al. 2008). Continuity in team-based care arrangements may be facilitated over time through better recognition of and valuing the coordination and integration role (RACGP 2020), e.g., the general practice in patient-centred medical home (PCMH) models or opportunities for care coordinator or navigator roles.

> "Team-based models of care can also build capacity for a region or community..."

TEAM-BASED CARE FOR COMMUNITIES AND POPULATIONS

Team-based models of care can also build capacity for a region or community, providing a workforce model that addresses population needs and goals. The way in which people access health care in rural and remote areas, for example, differs from those in metropolitan areas, with smaller facilities, less infrastructure and the need to provide a broader range of services to a more widely distributed population (AIHW 2019). Implemented appropriately, team-based models of care can help to ensure that people in regional and remote areas are still receiving high quality care from appropriately trained and skilled health professionals roles.

TEAM-BASED CARE FOR THE PROVIDER AND THE SYSTEM

Effective team-based care has been shown to improve clinician well-being and satisfaction and reduce burnout (Welp & Manser 2016; Rosen et al. 2018). Team members each working to the top of their scope of practice can bring benefits such as improved timeliness and access to care, reduced costs of service delivery and greater operational efficiencies (PC 2015).

BARRIERS TO TEAM-BASED CARE

While team-based care is recognised as important to the quality and safety of care delivery, barriers to its implementation have been identified to include: the impact on existing workflows; a lack of integrated electronic health records or interoperable software; poor communication; payment systems that do not incentivise team-based care; a lack of dedicated infrastructure and resourcing; maldistribution of health professionals and services in some regions; regulatory requirements restricting scope of practice; variations in understanding about the roles of different care providers; hierarchies between professional roles and over occupational tenure that discourage open discussion; poor integration within and between organisational systems; a lack of external accountability of service providers; poor culture (e.g. team members who are ambivalent or have diverse motives); and a lack of leadership (Rosen et al. 2018; Smith et al. 2018; Naccarella, et al. 2013; Hepworth & Marley 2010; Russell et al. 2018). It is crucial to consider the influence of these when implementing team-based care.

While team-based care is recognised as important to the quality and safety of care delivery, enabling team-based care requires sector-wide attention to the following areas.

POPULATION HEALTH PLANNING & DATA-DRIVEN MODELS OF CARE

Collaborative population health planning is central to the implementation of integrated, team-based health and social services.

Practices and services at the local level must be supported to engage in collaborative population health planning and the co-design of models of care to meet identified needs in their community.

Establishment of the Primary Health Care Data Asset must be a priority, supported by sound data and information governance standards and processes.

CLINICAL GOVERNANCE

A clinical governance framework for team-based care is needed that can be adapted by teams to reflect the local context and meet the needs of patients and the local community.

A CULTURAL SHIFT, WITH PATIENT, FAMILY AND CARER INCLUSION

Team-based care requires a cultural shift, with success dependent on approaches that promote person-centredness, value to the patient, equality between team members, and strong written and verbal communication.

Patients, family and carers are central members of the team. Families and carers should be identified early, with intentional, purposeful and active inclusion throughout assessment, treatment, care and recovery.

PERSON-CENTRED GOALS, MEASURES AND INDICATORS

Systematic use of clinical and social indicators, measures of self-care capability and activity, and PRMs support patient-centredness in team-based care.

Investment in primary care data infrastructure and linkage across the hospital, social and other sectors is needed to enable real-time, shared decision making.

INTEROPERABLE DATA AND TECHNOLOGY

Digital enablement can drive improved accessibility, quality, safety and efficiency through team-based models of care.

Privacy and confidentiality require assurance. A consistent data governance framework is needed for cross-sector teams to support a patient pursue their goals. Further, patients, their families and carers require an understanding of their rights for privacy and confidentiality in team-based models of care and with the use of digital health.

INVESTMENT IN INFRASTRUCTURE

A one-off investment in the physical infrastructure within practices and services is needed to catalyse the establishment of environments conducive to team-based models of care.

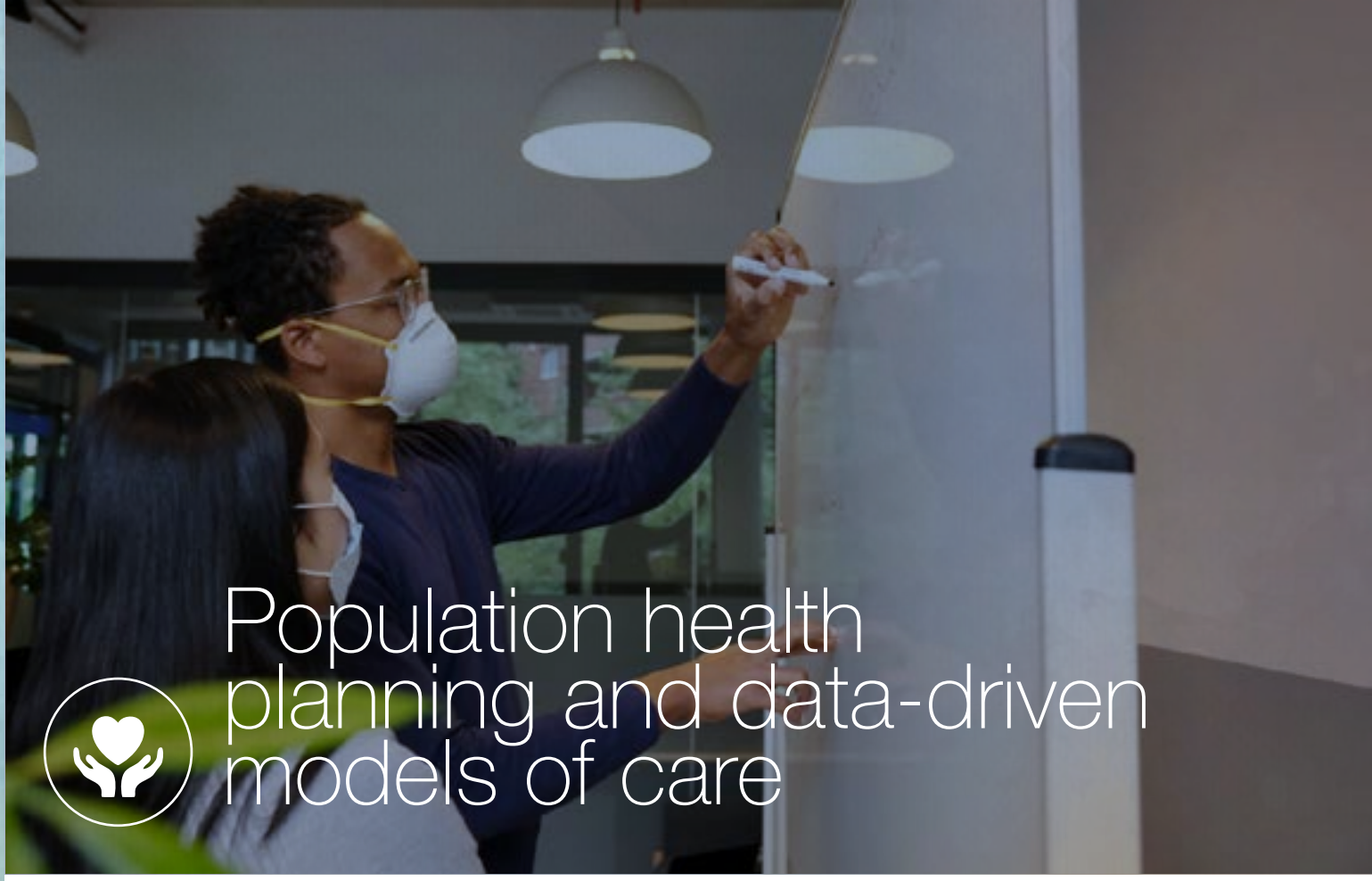
WORKFORCE DEVELOPMENT

Education programs and continuing professional development (CPD) requirements must foster capabilities in interprofessional practice, the use of data in routine clinical practice and digital health in order to support team-based care.

Practices and services must be able to provide learners with opportunities to experience how high-functioning teams work.

FUNDING MODELS

Blended, bundled and capitation funding models will be needed. The design of funding models must recognise where the costs and rewards of providing care differently are borne, support dedicated time for population health planning and developing team-based models of care, and incentivise the desired patient and population health outcomes.



Population health planning and data-driven models of care

Collaborative population health planning is central to the implementation of integrated health and social services (Anstey et al. 2018). At the regional level, needs assessments are undertaken by public health departments and Primary Health Networks, providing systematic methods for identifying unmet health and health care needs in communities. Done collaboratively, population segmentation and risk stratification enables an understanding of requirements from the perspective of the system as a whole, rather than at one point in time for treatment of a specific condition (NHS 2014).

Needs assessments can be used to target health improvement initiatives for populations and communities, with models of care co-designed to be preventive and proactive, not just responsive to patient demand. Then, data can be used to drive models of care by teams collectively agreeing with patients and service users a small number of measures as the most important ways of understanding the quality of health care to be provided (Shah 2019).

Information held by practices and services for the clinical management of their patients and clients is valuable in population health planning, but must also be recognised as a business asset. While its use is strictly regulated, the potential for its collection to impact resourcing decisions, and therefore the resulting service provision by practices and services, must also be considered. Sound data and information governance is required to ensure any use is fair, legal and secure.

Current fee-for-service funding models and available incentives limit the ability of individual practices and services to participate in population health planning, but this is crucial in meeting individual and community needs.

> "Done collaboratively, population segmentation and risk stratification enables understanding of requirements from the perspective of the system as a whole..."

RECOMMENDED ACTIONS

Practices and services at the local level, across the health and social care system, must be supported and incentivised to actively engage in the population health planning process, as well as the co-design of models of care to meet the identified health and health care needs in their community.

The Primary Health Care Data Asset (AIHW 2019) must be established as a priority to inform population health planning, supported by sound data and information governance standards and processes. The adequacy of data for population segmentation and risk stratification at a local level needs consideration.

The co-design of models of care must be undertaken within a context of:

- clear accountability to the population segment;
- defined and aligned values, goals and performance indicators at the system level; and
- quality and safety data driving each member of the team to practice at the top of their scope, and informing regulatory changes to extend or expand scopes.

Clinical governance

The need for effective governance frameworks for integration at the system level has long been identified as a priority for the Australian health system (Jackson 2008; Nicholson et al. 2014). However, attention is also needed on clinical governance at the level of individual clinicians, across distributed and independent practices/services, working within teams.

Multidisciplinary teams have been comprised in various ways, with multiple disciplines taking on a diversity of roles and collaborating in different ways (Saint-Pierre et al. 2014). Regardless of the team's structure and the roles of members, it is crucial to systematise how the team will practically work together, with the team agreeing on:

- the population segment being targeted;
- the roles of each team member, ensuring each member contributes to the top of their scope of practice;
- the care they will provide in accordance with evidence-based protocols and the actions expected of each member in specific circumstances (e.g. escalation and referral through Standing Orders; protocols for responding to clinical incidents and complaints);
- how shared goals will be created that address the complexity of each patient or client's needs;
- information governance, data quality and methods of communication; and
- how accountability will be measured and monitored, with dedicated time to review the data and outcomes being achieved and continuously improve the model of care.

Team performance can be evaluated by drawing on care quality and safety data (i.e. the degree to which care is consistent with current guidelines and professional knowledge, and the risk of preventable harm is minimised), patient experience and clinical patient outcomes (Rosen et al. 2018). With such data, care models can ensure each member of the team practises at the top of their scope of practice, while ensuring quality and safety standards are met.

Different population segments will likely require different models of team-based care, which may be influenced by such factors as the location of services; oversight, accountability and risk management (including medico-legal risk); role flexibility and scopes of practice; the time horizon over which the team is to work interdependently; and funding models (AHHA 2019; RACP 2018; Saint-Pierre et al. 2018). A spectrum of approaches may be appropriate that are place, person and time-dependent, rather than more rigid approaches.

RECOMMENDED ACTIONS

A clinical governance framework for team-based care is developed that:

- can be adapted by teams to reflect the local context and meet the needs of patients and the local community;
- allows local ownership and shared agreement around the transition to team-based models of care; and
- spans and links the jurisdictional and professional boundaries within our health system and other sectors (e.g. aged, disability, social care, housing, justice).

A cultural shift, with patient, family and carer inclusion

Team-based care requires a cultural shift, with success dependent on: approaches that promote patient-centredness; demonstration of the value proposition for the patient, care providers and the system; equality between team members; and strong written and verbal communication. Team culture and trust are critical for promoting effective teamwork (Rosen et al. 2018). This should recognise the patient, family and carers as part of the team.

Patients need to identify and have a relationship with the team collectively. Patients should understand the different roles of those in the team providing care, with team members continuously empowering the patient, their family and carers, and demonstrating that they are working together as a coherent entity. Trust can be gained when it is clear that team members are sharing information and communicating to achieve shared goals, and that trust can be transferred to other team members, e.g. when transitions of care occur with emphasis on the purpose being to utilise the other team member's competence (Schottenfeld et al. 2016).

Family and carers have a valid and established place in team-based models of care. They can provide valuable information to inform care given their deep commitment to their loved one's recovery, their lived experience of giving care and their comprehensive knowledge of the patient. Team-based models of care should be designed to ensure intentional, purposeful, active inclusion of families and carers in care planning, treatment decisions, discharge planning and recovery.

The healthcare sector has been described as being hierarchical, with a chain of command and relationships defined by subordination. Mistrust and resentment are reported to be generated when status becomes a barrier to respectful communication (Armstrong 2013). Team-based care requires a structure where each member, at the individual and practice/service level, is recognised as key to success, working collaboratively and with accountability to a shared goal.

RECOMMENDED ACTIONS

- Patients, family and carers need to be informed decision-makers in the adoption of team-based care, with a clear understanding of the value of biopsychosocial models (addressing any misperception of them just being cost saving models). Families and carers should be identified early, with intentional, purposeful and active inclusion throughout care.
- Cooperation and coordination is needed across the health system and other sectors (e.g. aged, disability, social care, housing, justice, education) to support collaborative team structures and to adopt new measures of outcome and accountability.

"Team-based models of care should be designed to ensure intentional, purposeful, active inclusion of families and carers..."

Person-centred goals, measures and indicators

A critical component of person-centred care is shared decision-making, personalising clinical decisions by applying the evidence base to the preferences and context of the patient, their family and carers, and enabling proactive care. Collaborative goal setting has been shown to be important in engaging people more actively in their care and improving outcomes (Brewer, et al. 2014; Armstrong 2008). Shifting the goals of each discipline to those of the individual can reduce conflict within a team, increase team motivation and enable the evaluation of outcomes (Armstrong 2008).

Establishing effective goals requires a shared understanding between all health care providers in the team about the person's goal and expectations for their health care in the short-, medium- and long-term; the clinical situation (including diagnosis, treatment options and clinical goals); and the person's values, needs and preferences about their health and care (ACSQHC 2019a).

There are various clinical and social indicators, as well as measures of self-care capability or activity, available to support a team's understanding of a person's context. Examples include adverse childhood event scores, frailty scores, health literacy scores, patient activation measures, demographics and social determinants of health. These can be used to support health professionals to tailor information, schedule screening and improve shared decision-making. Currently, however, these indicators and measures are not systematically used by service providers in Australia (Nichols, et al. 2020).

There is an increasing use of Patient Reported Measures (PRMs) as part of routine clinical practice. They are used in care planning and decision-making, improving communication between individuals and care providers to provide timely care based on collaboratively identified patient needs (ACSQHC 2019b; Chen et al. 2013; Ishaque et al. 2019; Rutherford et al. 2020).

In Australia, PRM programs are being implemented in public hospital and health services in different states and in various ways (e.g. Rutherford et al. 2020; VAHI & SCV 2019; Thompson et al. 2016). Implementation in primary care settings in Australia appears more fragmented or absent altogether, although the shared intentions expressed by governments to pay for value and outcomes and for joint planning and funding (Australian Government 2020) provide opportunity for an integrated approach in this area. Data linkage projects such as those in NSW (NSW Health 2019) will be important in informing such transformation.

Clinical registries are also increasingly incorporating PRMs, although few are currently used for real-time monitoring as part of routine clinical practice. The collaborative process necessary for embedding PRMs in routine care has also been considered by some disease-specific groups, e.g. oncology (COSA 2018) and renal (Morton et al. 2019). Implementation research is underway (CIC Cancer 2020).

RECOMMENDED ACTIONS

The establishment of shared goals and priorities must be embedded in practice through:

- Investment in primary health care data infrastructure and linkage across the hospital, social and other sectors to enable real-time, shared decision making.
- Multi-stakeholder commitment to the systematic use of clinical and social indicators, measures of self-care capability and activity, and PRMs as reportable measures for population health monitoring.
- Cross-sector identification and implementation of a set of valid, reliable and appropriate indicators and measures that may be initiated across all patient populations and conditions, and that may be supplemented with population segment- or condition-specific PRMs, to support a comprehensive and holistic person-centred approach to care over time.
- Practice support to implement the use of these indicators and measures as part of practice.
- The reporting of indicators and measures being coordinated at the national, state and territory, regional and service level.

Interoperable data and technology

Digitally-enabled, team-based models of care can drive improved accessibility, quality, safety and efficiency, and is a strategic priority in the National Digital Health Strategy (ADHA 2017).

Digitally-enabled models of care are being trialled through a 'test bed' framework, allowing the creation of supportive policy, regulatory and governance frameworks, and evaluation and refinement of the technology and models of care, with the aim of scaling up (ADHA 2018). There are 15 projects currently underway evaluating implementation of a range of digital technologies, with many contributing to team-based care.

Electronic health records are fundamental in the provision of team-based care. However, the lack of standards and regulation of electronic health records has led to inconsistent structures, data elements, and use of clinical terminologies and classifications. This has hindered capability for transfer of clinical data between electronic health records for: clinical purposes; linking individual health data for integration of care across different sectors of the health care system; and reliable extraction of patient data for practice improvement and research purposes (Gordon et al. 2016).

Shared care plans were introduced as a central element of the Health Care Homes trial, leading to the development of minimum requirements for shared care planning software (Department of Health 2017). These include the ability to set target goals with measurable success criteria, and patients and other health care providers being able to access and contribute in real time. Unfortunately, software was described by practice staff as 'clunky' and 'cumbersome' with an inability to auto-populate patient information from clinical management systems. Concern was also raised about the interoperability of different software used by different providers in the region (Health Policy Analysis 2019).

Digital platforms that enable communication, which may be commerical, not-for-profit and government-owned, are also important for enabling team-based care. Privacy and security considerations need to be assured.

"Digital platforms that enable communication ... are also important for enabling team-based care."

RECOMMENDED ACTIONS

- Standards must be developed for clinical management systems and software vendors to support a consistent and interoperable approach to the collection and use of indicators and measures, and shared care planning across all health professions and providers.
- Technology must support desired clinical workflows, the use of electronic health records, and the development and monitoring of shared care plans (rather than multiple care plans developed independently).
- A data governance framework is needed that specifies how health data is acquired, maintained and shared, across the health system and with other sectors (aged, disability, social care, housing, justice), for both providers and patients to achieve the identified goals of care.
- Patients, their families and carers participating in team-based care require an understanding of their rights for privacy and confidentiality in cross-sector teams and with interoperable technology.

Investment in infrastructure

Infrastructure in general practice and specialty care has typically developed over time to support a medicalised, rather than biopsychosocial approach to care. The physical infrastructure within practices and services therefore may not foster the interprofessional interaction and communication conducive to team-based models of care. For specialists, e.g., this includes being less hospital-centric in the way they work (RACP 2018). Facilities, equipment and shared spaces, virtually or physically co-located, need investment to support team-based models of care in both general practice and specialty care.

"Infrastructure grants will support practices and services to create the physical enviroments important to providing team-based care."

RECOMMENDED ACTION

- One-off infrastructure grants will support practices and services to create the physical environments important to providing team-based care

Workforce development

The knowledge, skills and attributes (KSA) underlying teamwork in health care settings have been identified, and include communication, situation monitoring, mutual support, and a team orientation (Rosen et al. 2018). Acknowledging that multidisciplinary team care is a key feature of contemporary models of health care and that effective teams improve patient care, interprofessional learning (IPL) competencies have been adopted by members of the Health Professions Accreditation Collaborative Forum to use in the accreditation of health profession programs (HPACF 2018).

Further, realising the benefits of team-based care requires the health workforce to have capabilities in data analysis, service evaluation and quality improvement; co-design; clinical governance; digital health and the use of emerging technologies; managing conflicting goals and expectations; and supporting self-management. New roles must also be embraced, e.g. to bridge clinical and technology areas and to support care coordination and system navigation.

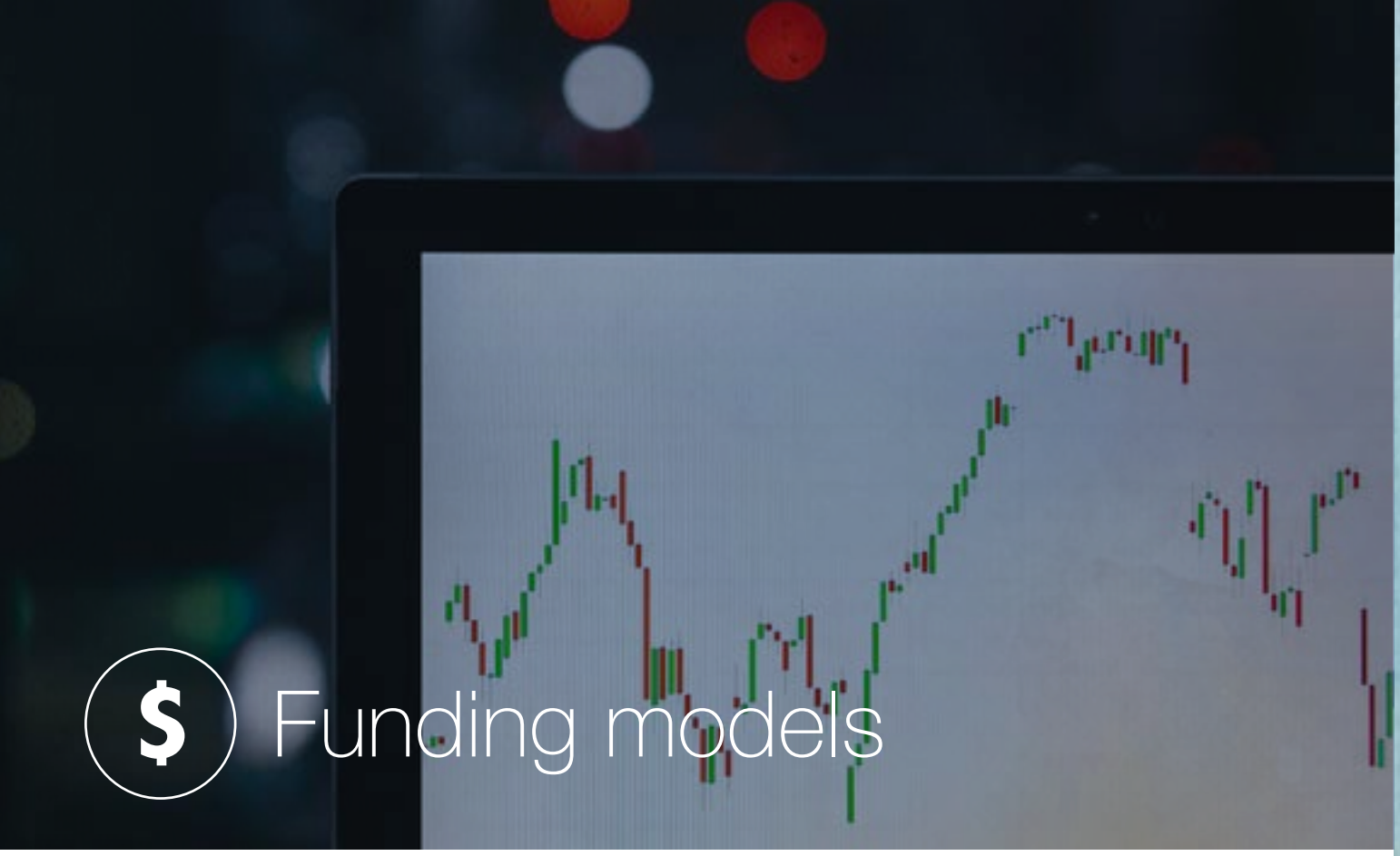
Clinical placements are a critical component to developing these skills, and there must be sufficient health services to provide experiences of how high-functioning teams operate in team-based models of care. Experience of care models that are less place-based and more flexibly-delivered will be important.

"Placements must be able to provide sufficient experiences of how high functioning teams operate."

RECOMMENDED ACTIONS

Continued support and accountability is required to ensure education programs leading to registration or recognition as a health professional, and continuing professional development (CPD) requirements:

- foster and assess IPL competencies;
- increase awareness of the evidence-based use of indicators and measures in routine clinical practice (including clinical and social indicators, measures of self-care capability and activity and PRMs);
- improve digital health capabilities and roles; and
- have model health services available in which learners can be placed to experience how high-functioning teams work.



Funding models

Funding arrangements influence the extent to which team-based care is supported (Naccarella et al. 2013), with fee-for service models providing little incentive to health providers to provide team-oriented care (Russell, et al. 2018; RACP 2018). Funding models that scale payment amounts according to profession, rather than the outcome achieved, are a further disincentive to team members working to the top of their scope of practice.

While a complete shift away from activity-based or fee-for-service models is unlikely to be desirable or feasible, innovative funding models such as blended, bundled and capitation payments, individually and collectively, should be explored. Funding models must recognise who bears the costs and rewards for delivering services differently, with incentives aligning with the desired outcomes.

The introduction of funding for patient 'enrolment', e.g. with a general practice, may provide the mechanism for achieving accountability in team-based care arrangements. Investment in research is needed to evaluate team-based models of care to best modify and adapt health care approaches (RACP 2018).

Funding models need to ensure providers can dedicate time to meet deliberately and incidentally about individual patients, as well as collect and review data and contribute to population planning and the development of models of care.

"Innovative funding models such as blended, bundled and capitation payments, individuals and collectively, should be explored."

RECOMMENDED ACTIONS

Funding models are needed that:

- incentivise the use of indicators and measures in routine clinical practice for team-based care (including PRMs and measures of self-care capability and activity), with the longer-term intent of funding models that incentivise improved outcomes;
- support health providers to contribute to population health planning and the development of models of care;
- ensure funding for patient 'enrolment' creates accountability for enabling team-based care; and
- facilitate greater flexibility in how team-based models of care achieve desired outcomes, with government policy and funding aligning to meet patient and local community needs.

Health system research must be prioritised to inform the transformation to team-based models of care.

References

Anstey, M, Burgess, P & Angus, L 2018, Realising the potential of health needs assessments, Australian Health Review, vol. 42, pp. 370-373.

Armstrong, H 2008, The benefits and challenges of interdisciplinary, client-centred, goal setting in rehabilitation, New Zealand Journal of Occupational Therapy, vol. 55, no. 1, pp. 20-25.

Armstrong, J 2013, Leadership and team-based care, Virtual Mentor, AMA Journal of Ethics, vol. 13, iss. 6, pp. 534-537.

Australian Commission for Safety and Quality in Health Care (ACSQHC) 2011, 'Patient-centred care: improving quality and safety through partnerships with patients and consumers, viewed 19 October 2020, https://www.safetyandquality.gov.au/sites/default/files/migrated/PCC_Paper_August.pdf

ACSQHC 2019a, 'Implementing the comprehensive care standard – Identifying goals of care', viewed 20 August 2020, https://www.safetyandquality.gov.au/sites/default/files/2019-06/implementing-the-comprehensive-care-standard-identifying-goals-of-care-final-accessible-pdf-24-apr-2019.pdf

ACSQHC 2019b, 'Evidence on PROMs', viewed 14 October 2020, https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-reported-outcomes/evidence-proms

ACSQHC 2019c, 'Comprehensive care standard – Comprehensive care plan, viewed 19 October 2020, https://www.safetyandquality.gov.au/sites/default/files/2019-07/acsqhc_cc_ee4_fact_sheet_d9accupdated_july_23.pdf

Australian Digital Health Agency (ADHA) 2017, Australia's National Digital Health Strategy, viewed 30/1/2020, https://conversation.digitalhealth.gov.au/sites/default/files/adha-strategy-doc-2ndaug_0_1.pdf

ADHA 2018, Digital Health Test Beds program, viewed 30/1/2020, https://conversation.digitalhealth.gov.au/digital-health-test-beds-program

ADHA 2019, Critical roadmap to equip Australian health workers for global digital transformation, viewed 30/1/2020, https://www.digitalhealth.gov.au/news-and-events/news/media-release-critical-roadmap-to-equip-australian-health-workers-for-global-digital-transformation

Australian Government Council on Federal Financial Relations 2020, National Health Reform Agreement – Addendum 2020-25, viewed 14 October 2020, http://www.federalfinancialrelations.gov.au/content/npa/health/other/NHRA_2020-25_Addendum_consolidated.pdf

Australian Government Department of Health 2017, Fact sheet: Minimum requirements of shared care plans, viewed 29/1/2020, https://www1.health.gov.au/internet/main/publishing.nsf/Content/health-care-homes-cp/$File/Minimum%20requirements%20shared%20care%20plans_December.pdf

Australian Healthcare and Hospitals Association (AHHA) 2019, Blueprint Refresh Working Group on workforce feedback.

Australian Institute of Health and Welfare (AIHW) 2016, Australia's health 2016, viewed 6/10/2020, https://www.aihw.gov.au/getmedia/ca0b4c1b-a675-472e-942d-06774c058d27/AH16-1-1-what-is-health.pdf.aspx

Australian Institute of Health and Welfare (AIHW) 2019a, Primary health care data development, viewed 7 October 2020, https://www.aihw.gov.au/reports-data/health-welfare-services/primary-health-care/primary-health-care-data-development

Australian Institute of Health and Welfare (AIHW) 2019, Rural and remote health, viewed 28/1/2020, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health/contents/access-to-health-care

Black Dog Institute 2019, Social prescribing: linking patients with non-medical support, viewed 28/1/2020, https://www.blackdoginstitute.org.au/news/news-detail/2019/02/28/social-prescribing-linking-patients-with-non-medical-support

Brewer, K, et al. 2014, Addressing the challenges of collaborative goal setting with children and their families, Physical and Occupational Therapy in Pediatrics, vol. 34, iss. 2, https://www.tandfonline.com/doi/abs/10.3109/01942638.2013.794187?scroll=top&needAccess=true&journalCode=ipop20

Chen, J, Ou, L, Hollis, S 2013, A systematic review of the impact of routine collection of patient reported outcome measures on patients, providers and health organisations in an oncologic setting, BMC Health Services Research, vol. 13, iss. 211.

Clinical Oncology Society of Australia 2018, Implementing monitoring of patient-reported outcomes into cancer care in Australia, viewed 31/1/2020, https://www.cosa.org.au/media/332504/cosa_pros_think_tank_report_final.pdf

Cohen SG, Bailey DE. What makes teams work: effectiveness research from the shop floor to the executive suite. J Manage 1997;23(3):239-290. In: https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care#ref51

Continuous Improvement in Care Cancer 2020, CIC Cancer project, viewed 31/1/2020, https://www.ciccancer.com/

Consumers Health Forum of Australia 2019, Social prescribing – a new way to think about health care, viewed 28/1/2020, https://chf.org.au/blog/social-prescribing-new-way-think-about-health care

Densen, P 2011, Challenges and opportunities facing medical education, Transactions of the American Clinical and Climatological Association, vol. 122, pp. 48-56, viewed 28/1/2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3116346/pdf/tacca122000048.pdf

Farre, A & Rapley, T 2017, The new old (and old new) medical model: four decades navigating the biomedical and psychosocial understandings of health and illness, Healthcare, vol. 5, iss. 88.

Harris, M, Dennis, S, Pillay, M 2013, Multimorbidity – negotiating priorities and making progress, Aust Fam Phys, vol. 42, no. 12, pp. 850-854, viewed 28/1/2020, https://www.racgp.org.au/afp/2013/december/multimorbidity-priorities/

Harrison, C, Henderson, J, Miller, G, Britt, H 2016, The prevalence of complex multimorbidity in Australia, Australian and New Zealand Journal of Public Health, vol. 40, no. 3, pp. 239-44, viewed 28/1/2020, https://onlinelibrary.wiley.com/doi/pdf/10.1111/1753-6405.12509

Health Policy Analysis 2019, Evaluation of the Health Care Homes program – Interim report 2019 – Vol 1 Summary report, Australian Government Department of Health, Canberra.

Health Professions Accreditation Collaborative Forum (HPACF) 2018, Position statement – Interprofessional learning, viewed 28/8/2020, http://hpacf.org.au/wp-content/uploads/2018/11/Forum-statement-IPE-Update-Nov-2018.pdf

Hepworth, J & Marley, H 2010, Health care teams – a practical framework for integration, Aust Fam Phys, vol. 39, no. 12, pp. 969-971.

HRH Human Resource Center 2020, Why is teamwork in health care important? HRH Resource Center, viewed 28/1/2020, https://www.hrhresourcecenter.org/HRH_Info_Teamwork.html

Ishaque S, Karnon, J, Chen, G, et al. 2019, A systematic review of randomised controlled trials evaluating the use of patient-reported outcome measures (PROMs). Quality of Life Research: an International Journal of Quality of Life Aspects of Treatment, Care and Rehabilitation, vol. 28, no. 3, pp. 567–592.

Jackson, C, Nicholson, C, Doust, J, et al. 2008, Seriously working together: integrated governance models to achieve sustainable partnerships between health care organisations, Med J Aust, vol. 188, iss. 8, pp. s57, viewed 28/1/2020, https://www.mja.com.au/journal/2008/188/8/seriously-working-together-integrated-governance-models-achieve-sustainable

Mitchell G.K., Tieman, J.J., and Shelby-James T.M. (2008), Multidisciplinary care planning and teamwork in primary care, Medical Journal of Australia, Vol. 188, No. 8, p.S63.

Morton, R, Lioufas, N, Dansie, K, et al. 2019, Use of Patient-Reported Outcome Measures and Patient-Reported Experience Measures in renal units in Australia and New Zealand: a cross-sectional survey study: PROMs and PREMs in ANZ renal hospitals, Nephrology, vol. 25, iss. 1.

Nacarella, L, Greenstock, L, Brooks, P 2013, A framework to support team-based models of primary care within the Australian health care system, Med J Aust, vol. 199, iss. 5, pp. S22-S25.

NHS 2014, 'How to' guide: the BCF Technical Toolkit, viewed 7 October 2020, https://www.england.nhs.uk/wp-content/uploads/2014/09/1-seg-strat.pdf

NSW Agency for Clinical Innovation (ACI) 2017, Patient reported measures formative evaluation, viewed 29/1/2020, https://www.aci.health.nsw.gov.au/__data/assets/pdf_file/0005/405446/Patient-Reported-Measures-Program-Formative-Evaluation-Report_2017.pdf

NSW Health 2019, Lumos, viewed 14 October 2020, https://www.health.nsw.gov.au/lumos/Pages/default.aspx

Nichols, T, et al. 2020, 'Self-care for health: a national policy blueprint, Policy paper 2020-01, Mitchell Institute, Melbourne, viewed 8 October 2020, https://www.vu.edu.au/sites/default/files/mitchell-institute-self-care-for-health-a-national-policy-blueprint.pdf

Nicholson, C, Jackson, C, Marley, J 2014, Best-practice integrated health care governance – applying evidence to Australia's health reform agenda, Med J Aust, vol 201, iss. 3, pp. s64-s66, viewed 28/1/2020, https://www.mja.com.au/journal/2014/201/3/best-practice-integrated-health-care-governance-applying-evidence-australias

Northern Territory Primary Health Network (NTPHN) 2019, Electronic shared care planning tool, viewed 29/1/2020, https://www.ntphn.org.au/electronic-share-care-tool

Productivity Commission (PC) 2015, Efficiency in health, viewed 31 August 2020, https://www.pc.gov.au/research/completed/efficiency-health/efficiency-health.pdf

Rosella, L & Koras, K 2018, Putting a population health lens to multimorbidity in Ontario, Healthcare Quarterly, vol. 21, iss. 3, pp. 8-11, https://www.longwoods.com/content/25709/healthcare-quarterly/putting-a-population-health-lens-to-multimorbidity-in-ontario

Rosen, M, DiazGranados, D, Dietz, A, et al. 2018, Teamwork in health care: Key discoveries enabling safer, high-quality care, Am Psychol, vol. 73, iss. 4, pp. 433-450, viewed 28/1/2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6361117/pdf/nihms-990788.pdf

Royal Australian College of General Practitioners (RACGP) 2020, Funding priorities Position Statement October 2020, viewed 19 October 2020, https://www.racgp.org.au/FSDEDEV/media/documents/RACGP/Position%20statements/Funding-priorities.pdf

Royal Australasian College of Physicians (RACP) 2018, Physicians and integrated care discussion paper, viewed 14 October 2020, https://www.racp.edu.au/docs/default-source/advocacy-library/integrated-care-physicians-supporting-better-patient-outcomes-discussion-paper.pdf

Russell, G, Miller, W, Gunn, J, et al. 2018, Contextual levers for team-based primary care: lessons from reform interventions in five jurisdictions in three countries, Family Practice, vol. 35, no. 3, pp.276-284.

Rutherford, C, Campbell, R, Tinsley, M, et al. 2020, Implementing patient-reported outcome measures into clinical practice across NSW: mixed methods evaluation of the first year, Applied Research in Quality of Life, online access, https://doi.org/10.1007/s11482-020-09817-2.

Saint-Pierre, C, Herskovic, V, Sepulveda, M 2018, Multidisciplinary collaboration in primary care: a systematic review, Family Practice, vol. 35, no. 2, pp. 132-141.

Schottenfeld, L, Petersen, D, Peikes, D, et al. 2016, Creating patient-centered team-based primary care, Agency for Healthcare research and quality, viewed 28 August 2020, https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care

The Senate Community Affairs References Committee 2016, Medical complaints process in Australia, viewed 31 August 2020, https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MedicalComplaints45/Report

Shah, A 2019, Using data for improvement, BMJ, vol. 364, viewed 28 August 2020, https://www.bmj.com/content/364/bmj.l189

Smith, C, Balatabat, C, Corbridge, S, et al. 2018, Discussion paper – Implementing optimal team-based care to reduce clinician burnout, National Academy of Medicine, viewed 28/1/2020, https://nam.edu/wp-content/uploads/2018/09/Implementing-Optimal-Team-Based-Care-to-Reduce-Clinician-Burnout.pdf

Thompson, C, Sansoni, J, Morris, D, et al. 2016, Patient-reported outcome measures: an environmental scan of the Australian health care sector, Australian Commission on Safety and Quality in Health Care, viewed 29/1/2020, https://www.safetyandquality.gov.au/sites/default/files/migrated/PROMs-Environmental-Scan-December-2016.pdf

Victorian Agency for Health Information (VAHI) & Safer Care Victoria (SCV) 2019, Pilots underway to improve use of patient-reported outcomes, viewed 29/1/2020, https://www.bettersafercare.vic.gov.au/news-and-media/pilots-underway-to-improve-use-of-patient-reported-outcomes

Welp, A & Manser, T 2018, Integrating teamwork, clinician occupational well-being and patient safety – development of a conceptual framework based on a systematic review, BMC Health Services Research, vol. 16, iss. 281, pp. 1-44, viewed 28/1/2020, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4950091/pdf/12913_2016_Article_1535.pdf

ahha
australian healthcare & hospitals association
the voice of public healthcare®

Unit 8, 2 Phipps Close
Deakin ACT 2600

PO Box 78
Deakin West ACT 2600

P. 02 6162 0780
F. 02 6162 0779
E. admin@ahha.asn.au
W. ahha.asn.au

facebook.com/AusHealthcare
@AusHealthcare
linkedin.com/company/australian-healthcare-&-hospitals-association

ABN 49 008 528 470