Collaborative Care Checklist

Purpose

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

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

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

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

What you can bring to the team

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

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

Teamwork Enablers

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

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

System Enablers

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

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

Collaboration Models you can adopt

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

  Shared medical appointments are where a cohort of patients with similar health concerns attend appointments together to receive education and clinical advice. RACGP - Shared medical appointments
- **General Practice in Aged Care Incentive**
  - Collaboration between primary care providers and aged care to improve continuity of care and care planning with allied health and pharmacy +/- other specialists for the patient's ongoing care.

  General Practice in Aged Care Incentive | Australian Government Department of Health, Disability and Ageing
- **Aboriginal Community Controlled Health Service (ACCHS) model**
  - Culturally safe, comprehensive, community-led care with multidisciplinary teams (GPs, Aboriginal Health Practitioners/Workers, nurses, allied health, social supports).
    Aboriginal Community Controlled Health Organisations - NACCHO
- **Health Pathways-enabled Virtual Multidisciplinary Teams**
  - Practice team uses local HealthPathways for evidence-informed assessment/management, referral criteria and patient resources; co-developed by local GPs and specialists.
    HealthPathways
    What is a virtual multidisciplinary team (vMDT)? - PMC
    Multidisciplinary services | Living well in multi-purpose services | Agency for Clinical Innovation
- **GP-led Patient-Centred Medical Home**
  - Usual GP + practice nurse + in-practice/partnered allied health; team huddles; proactive registers; shared care plans; telehealth follow-ups.
  - Variation: add a non-dispensing practice pharmacist to lead medicines optimisation and audits.
    Key Principles of Patient Centred Medical Homes | Navigating the Healthcare Neighbourhood

Resources and Tools

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

Examples in Practice

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

Further Reading

MBS online

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

Mental health Case Conferencing

- PDF - Mental Health Case Conferencing.pdf

Tips for Nurses: Case Conferences

- Tips for nurses: Case conferences
- Case Conference Checklist FINAL Dec 2025

Interprofessional collaboration: three best practice models of interprofessional education
Interprofessional collaboration: three best practice models of interprofessional education - PMC

Footnote references

1 - Implementing team-based primary care models: a mixed-methods comparative case study in a large, integrated health care system - PMC

2 - RACGP - Collaboration and multidisciplinary team-based care