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How does teamwork support GPs and Allied Health Professionals to work together?

A well coordinated health system provides a comprehensive and continuous experience for the patient, promotes teamwork between practitioners, and the coordination of service delivery organisations.[1,2,3] Improving teamwork between General Practitioners (GPs) and Allied Health Providers (AHPs) has been an ongoing challenge for Australia due to the split responsibility for primary health care between Commonwealth and State jurisdictions leading to incompatible systems of funding and accountability.[4] Integration of services at the regional level has been identified as a priority in Australia's Primary Health Care Strategy.[5] This issue of *RESEARCH ROUNDup* highlights Australian research and systematic reviews that have addressed the role of teamwork in system integration in primary health care.

Introduction

Teamwork is strongly influenced by structures and mechanisms that support or undermine system integration. A 2009 systematic review[6] identified ten key elements of a successfully integrated health system. Such a system:

- ⇒ has centralised planning and coordination of all services for the population group served
- ⇒ places the patient and their experience at the centre of the integration effort
- ⇒ provides services for an identified patient group in a geographic area
- ⇒ standardises care by inter-professional teams using shared protocols, defined roles and responsibilities, and efficient communication channels
- ⇒ has protocols and procedures to measure care processes and outcomes for continuous quality improvement
- ⇒ uses shared electronic health records
- ⇒ bridges organisational cultures with visionary leadership
- ⇒ overcomes physician resistance through financial incentives and improvements to the quality of their working life
- ⇒ uses governance structures that promote coordination, flatter organisational structures and community representation
- ⇒ recognises that integration processes may increase costs before they provide savings.[6]

Funding in the Australian context

In Australia's health system, multiple funding sources and the independence of providers may provide challenges to achieving integration. For example, the Australian Government's Enhanced Primary Care Program provides Medicare item numbers to remunerate GPs for multidisciplinary care planning and case conferencing. However, while AHPs in private practice are remunerated to provide services, there is no funding for their participation in case conferences, planning or assessment.[7] Similarly, the Victorian Primary Care Partnerships (PCPs), established in 2001 to improve coordination of planning and service delivery, experienced disengagement by GPs who had no means of remuneration to attend partnership meetings and activities.[8]

Integrated primary health care centres address funding imbalances by combining core funding, Medicare, and specific purpose funding, although it has been reported that this requires some ingenuity.[4,9] State funded Extended General Practice services, including HealthOne services in NSW, GP Plus centres in SA, and the nationally funded GP Superclinics use public funding to employ AHPs and other providers to work collaboratively with Medicare funded GPs.[9] Integrated primary health care centres may operate through co-location or in 'hub and spoke' models.[9] Other integrated models are used by the Victorian Community Health Services, some of which have GPs onsite. In some cases these GPs receive a salary or participate in an income sharing arrangement, while others use a co-located private practice model. Aboriginal Community Controlled Health Services use combined sources of funding to provide a variety of services for a defined population.[9]

Divisions of General Practice that undertake Commonwealth funded activities through the Access to Allied Psychological Services (ATAPS) program and the More Allied Health Services (MAHS) program are eligible to receive funding to enable AHPs to work with GPs.[9,10,11] Coordination and integration has best been achieved in the MAHS projects through co-location of AHPs in general practices, use of shared patient notes, and formal referral and feedback processes.[10]

Teamwork

How to better coordinate care within multidisciplinary teams and innovative models of primary health care delivery are themes of a series of systematic reviews published by the Australian Primary Health Care Research Institute.[3,12,13,14]

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The reviews found many factors that may influence the integration of GPs and AHPs, including the structure of the care delivery pathway, funding models, practice culture, types of information, activities, and services or funding that are exchanged between the parties and how this occurs. Governance of the relationship in terms of accountability, professionalism, autonomy and power also play a role.

The reviews also identified activities that support teamwork such as: clinical coordination,[13] communication systems,[14,15] attention to relationships between service providers,[13] and the use of guidelines and evidence based materials.[14] The use of multiple strategies,[15] co-located team members, smaller teams, and teams with greater occupational diversity appears to be more successful.[14,16] Other important factors are clear leadership, organisational support, encouragement of innovation and change, clear team goals, audit and evaluation, and regular team meetings.[16]

The Teamlink Study, a recently completed University of NSW project, developed and evaluated an intervention to enhance teamwork, communication and relationships between general practice, public or private nursing, and independent AHPs for patients with diabetes or cardiovascular disease. The project developed a practice work book, a referral directory, care plan templates, patient education materials, and held workshops and practice visits. Facilitation of teamwork was shown to be feasible but was constrained by structural barriers. Trust, communication and funding arrangements also influenced the success of the intervention.[17]

Teamwork is also being investigated by SACHRU (South Australian Community Health Research Unit), based at Flinders University. The project is looking at factors that enable or limit collaboration when treating patients with depression or diabetes.[18]

Barriers and enablers

Blurring of professional identity due to a misunderstanding of roles may be a barrier to teamwork.[16] Teamwork may challenge professional autonomy, professional values and ethics, and capacity for independent decision making, so it may not always be supported by professional groups.[2] Incentives to encourage teamwork need to be targeted towards not only individuals, but service provider organisations and the wider health system.[2] This may include support for co-location of AHPs in general practices, joint professional education, best practice guidelines and professional competency standards, capitation payments based on patient enrolment, team based bonuses, profit sharing, coordination through regional primary health care organisations, practice management, and electronic health record systems.

While limited evidence exists on the effect of specific incentives, it may be that practice level incentive payments need to be equitably distributed amongst team members. Teamwork may obscure deep seated inequalities[19] and incentives should not reinforce traditional hierarchies that promote task delegation rather than teamwork.[2]

Conclusion

Successful teamwork requires attention to the wider context in which it occurs. Incentives need to be used carefully and accompanied with rewards for achieving better quality, coordination and continuity of care.[2] Future planning for integrated care will need to proceed cautiously, with consultation, and community engagement.[9]

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