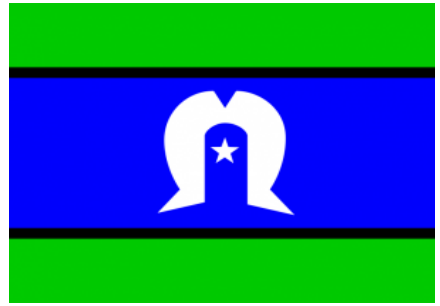
Beyond MDT Team Care Arrangements: Delivering Integrated Multidisciplinary Care That Truly Matters

Wednesday, August 6 2025

The content in this session is valid at date of presentation

Acknowledgement of Country

We would like to acknowledge the Wurundjeri people and other peoples of the Kulin Nation on whose unceded lands our work in the community takes place. We pay our respect to Aboriginal and Torres Strait Islander cultures; and to Elders past and present. We are committed to the healing of Country, working towards equity in health outcomes, and the ongoing journey of reconciliation.



Recognition of lived experience

We recognise and value the knowledge and wisdom of people with lived experience, their supporters and the practitioners who work with them and celebrate their strength and resilience in facing the challenges associated with recovery. We acknowledge the important contribution that they make to the development and delivery of health and community services in our catchment.

Housekeeping – Zoom Meeting

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Please ask questions via the Chat box

This session is being recorded

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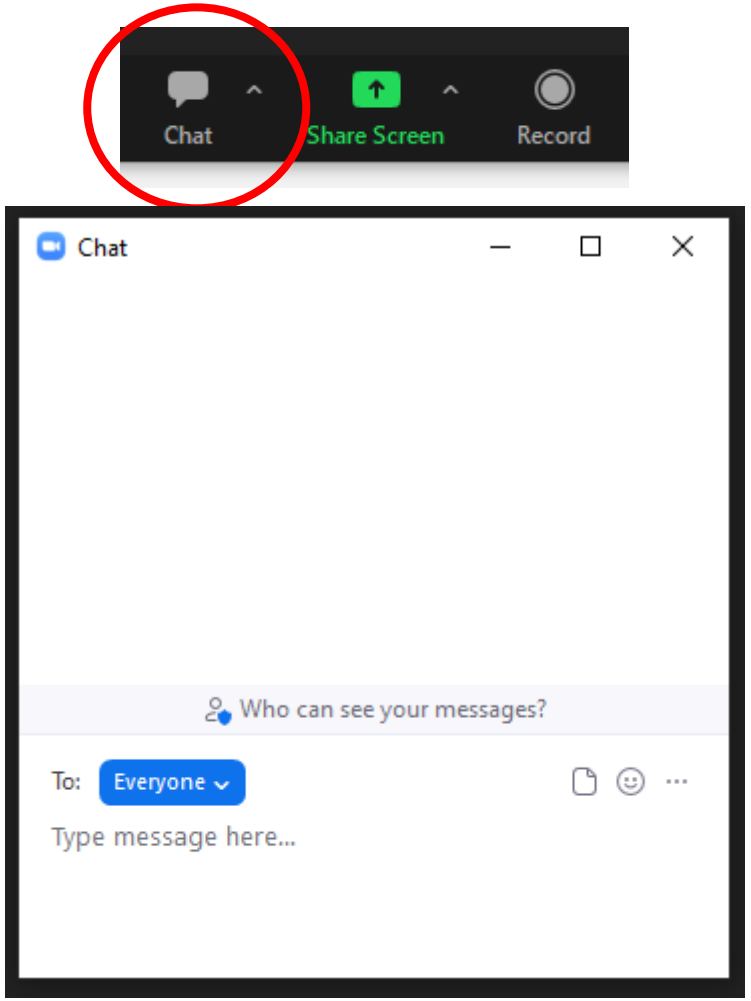

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   Computer: hover over your name and click the 3 dots
   Mac: hover over your name and click More
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   Done / Change / Rename

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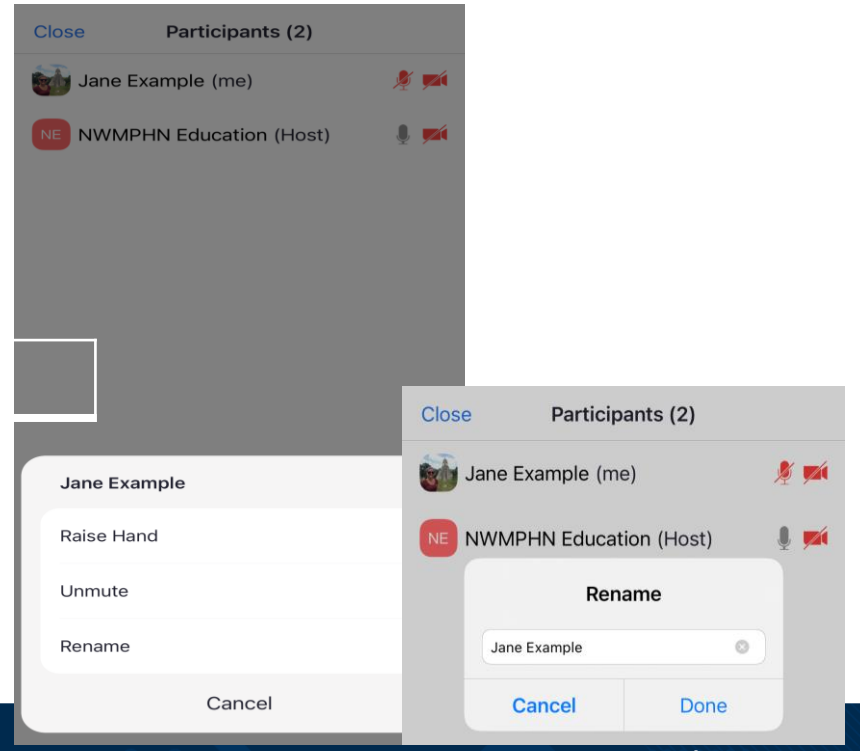

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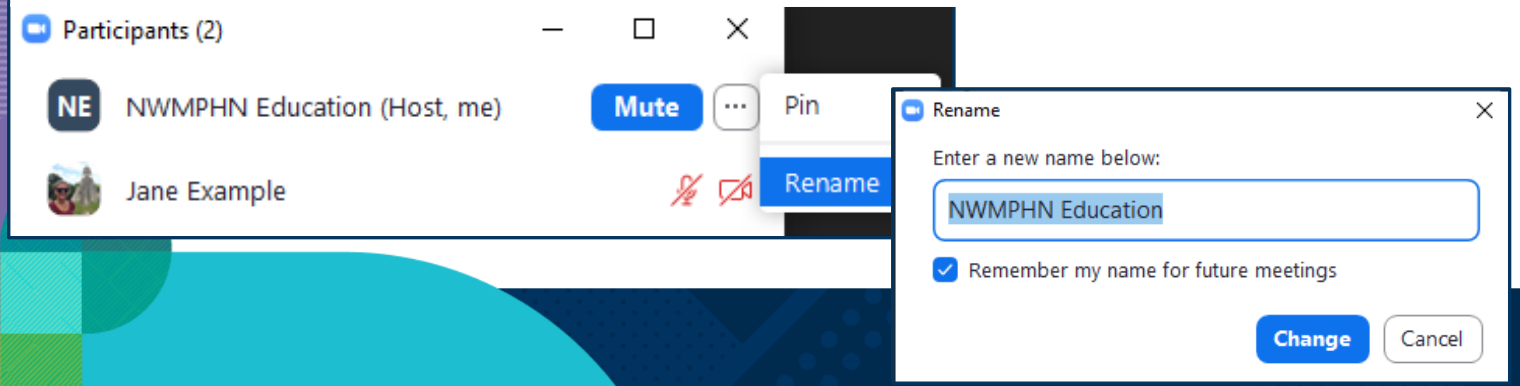

Speakers

Dr Paresh Dawda, GP - Prestantia Health and Next Practice Deakin

Dr Paresh Dawda is a General Practitioner with a portfolio of roles spanning clinical, leadership, academic and consultancy domains. As a clinician, he leads organisations and provides services for people with complex and chronic conditions across the ACT including those with disabilities, residing in aged care and palliative care.
View Dr Paresh's full speaker biography here: **Paresh Dawda | Prestantia Health**

Brooke Shelly, Pharmacist - Ontario Medical Clinic

Brooke Shelly BPharm, FPS CredPharm (MMR) is a Consultant Pharmacist working in General Practice (GP Pharmacist). She is a National Board Director of the Pharmaceutical Society of Australia (PSA), a member of the Advisory Network to the National Rural Health Commissioner and an Adjunct Senior Lecturer at La Trobe Rural Health School.

Dr Ryan Sheridan, GP Registrar - Ontario Medical Clinic

Dr. Ryan Sheridan MD, MPH is a Rural Generalist Registrar with ACRRM, Board Director (Doctors in Training) of the Rural Doctors Association of Australia (RDAA), Victorian state representative on the ACRRM Registrar Committee and AMA Rural and Regional Doctors Policy Council member.

Brooke and Ryan both work together at the Ontario Medical Clinic in Mildura and both sit on the Monash Rural Health School Community Advisory Committee (Mallee).

Agenda

Activity	Duration
Welcome & Housekeeping	6:30pm-6:40pm
Implications of MBS Chronic Care Item Changes *Dr Paresh Dawda*	6:40pm-6:50pm
Practice in Action - General Practice Multidisciplinary Team-based Care and an Allied Health Perspective *Brooke Shelly & Dr Ryan Sheridan*	6:50pm-7:20pm
Moving beyond teamwork *Dr Paresh Dawda*	7:20pm-7:40pm
Q&A & Reflections	7:40pm-8:00pm

Implications of MBS Chronic Care Item Changes

Dr Paresh Dawda

Beyond MDT Team Care Arrangements: Delivering Integrated Multidisciplinary Care That Truly Matters

Dr Paresh Dawda

6 August 2025

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Acknowledgment of Country

We acknowledge Traditional Custodians of the many lands on which we meet today.

We pay our respects to their Elders past and present, and extend that respect to all Aboriginal and Torres Strait Islander peoples joining us today.

We recognise the enduring connection that Aboriginal and Torres Strait Islander peoples have to Country—lands, waters, skies, and culture—and the deep knowledge systems grounded in relationships, reciprocity, and care.

As we come together, we reflect on the importance of collaboration and shared purpose—values that have long been practised by First Nations peoples and which also underpin our work in healthcare. Primary care thrives when grounded in strong relationships—between patients, clinicians, communities, and each other.

Let this be a space where we honour those traditions of care, listening, and learning, and where we build a culture of teamwork and trust that supports the health and wellbeing of all.

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Recognition

We’d like to acknowledge that the following presentation was developed in collaboration with Dr Walid Jammal of Hills Family Practice.

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MBS Chronic Care Changes

Aspect	Past (pre-1 July 2025)	New world! (from 1 July 2025)
Planning Items	GPMPs (Items 229, 721, 92024, 92055), TCAs (230, 723, 92025, 92056)	GPCCMPs: Single plan system (Items 965, 392, 92029, 92060)
Review Items	Separate TCA/GPMP reviews (Items 233, 732, 92028, 92059)	Unified review (Items 967, 393, 92030, 92061)
Fee Structure	Varied: e.g. GPMP $164.35, TCA $130.25, Review $82.10	Standardised: $156.55 for GPs, $125.30 for PMPs
Referral Requirements	Formal referral forms required; two collaborating providers for TCA	Referral letters only; no requirement for multiple collaborators
Allied Health Access	Up to 5 individual + group services via TCA	Same access but under GPCCMP; valid for 18 months from first service
Transition Arrangements	Current plans valid until 30 June 2027	Post-1 July 2027, GPCCMP mandatory for access
Support Roles	Assistance by practice nurses, Aboriginal health workers (within TCA)	Same support roles, also assist with GPCCMP
Eligibility	Chronic condition ≥6 months or terminal illness	Same eligibility, clinical discretion remains
MyMedicare Requirement	Not required	Mandatory use of enrolled practice for MyMedicare patients

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Why is chronic condition management important?

50% of All Australians are living with at least 1 of the 8 chronic conditions reported by AIHW

In 2022, 55% of all hospitalisations were related to a chronic condition

Primary care/general practice is crucial in the management of chronic conditions

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Two fundamental questions!

Do care plans make a difference?

What are the components of care plan that make the difference?

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General practice activity and care planning makes a difference

Source: https://www.health.nsw.gov.au/lumos/Factsheets/diabetes-early-gp.pdf

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Management of Diabetes in the Community Influences for Acute Care and Mortality

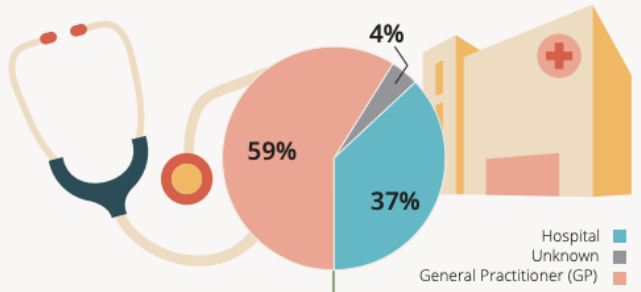
Impact of Diabetes Managed Early in General Practice

Emerging evidence suggests that detecting and managing diabetes in the general practice setting is associated with a lower risk of unplanned admissions to hospital. This highlights the importance of coordination between and continuity of care across the primary and acute care settings. Here we compare people over two years with diabetes that was first recorded in a general practice setting with those with diabetes that was first recorded in a hospital record.

Findings

Where diabetes diagnosis was first recorded

Diabetes diagnosis was much more commonly first recorded in the GP record



	People with diagnosis first recorded at the GP	People with diagnosis first recorded in hospital
Where diabetes diagnosis is first recorded varies by people's characteristics, such as remoteness of residence	Over half in cities or regional centres.	Up to two thirds living in remote and very remote area.
Proactive care in the community was more common for people who had their first recorded diabetes diagnosis in the GP record	Over the 2-year study: 50% have antidiabetic medications prescribed. More likely to have GP management plans and reviews. More likely to have blood pressure, cholesterol and HbA1c recorded.	Over the 2-years, 27% have antidiabetic medications prescribed.
Presentation to hospital was less common among people who had their first recorded diabetes diagnosis in the GP record	Over the 2-year study: • 16 GP visits • 2 ED presentations • 2 Hospital admissions • 8 Outpatient services.	Over the 2-year study: • 10 GP visits • 2 ED presentations • 4 Hospital admissions • 12 Outpatient services.
Mortality was lower for people who had their first reported diagnosis in the GP record	4% mortality across the study period.	6% mortality across the study period.

Care Plan Components and Supporting Evidence

Care Plan Component	Description	Evidence/Source
Patient-centred goals	Goals in patient's own words reflecting their values	Coulter et al. (2015) BMJ
Comprehensive assessment	Current diagnoses and clinical issues	MBS Review Taskforce (2020)
Functional and psychosocial assessment	ADLs, mental health, social needs	Bodenheimer et al. (2002)
Medication reconciliation and review	Current meds, adherence, side effects	NPS MedicineWise, HMR outcomes
Lifestyle assessment and interventions	Smoking, diet, activity, alcohol	NICE Guidelines (2020)
Self-management support	Education and skill-building for self-care	Wagner's Chronic Care Model
Coordination of team-based care	Roles, referrals, integrated care team	Ham et al. (2012)
Review and follow-up schedule	Planned intervals and escalation plan	RACGP Standards (2020), MBS GPCCMP
Documentation and information sharing	With patient and team, MyHR	ADHA (2022), HealthPathways
Consent and activation	Informed patient agreement	RACGP Standards (5th edition)

Why the changes?

- The MBS Taskforce deliberations:
  - Strong support for a reduction in red tape
  - About half of patients with a care plan never have a review (732) billed
- Recommendations:
  - Replace 721 and 723 with one item
  - Enable allied heath referral with a care plan
  - Remove red tape
  - Link care plans with enrolment to encourage continuity of care

https://www.health.gov.au/sites/default/files/documents/2020/12/taskforce-final-report-primary-care-report-on-primary-care.pdf

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The finances…

Think about what you do now and the weighting of reviews to care plans and TCA

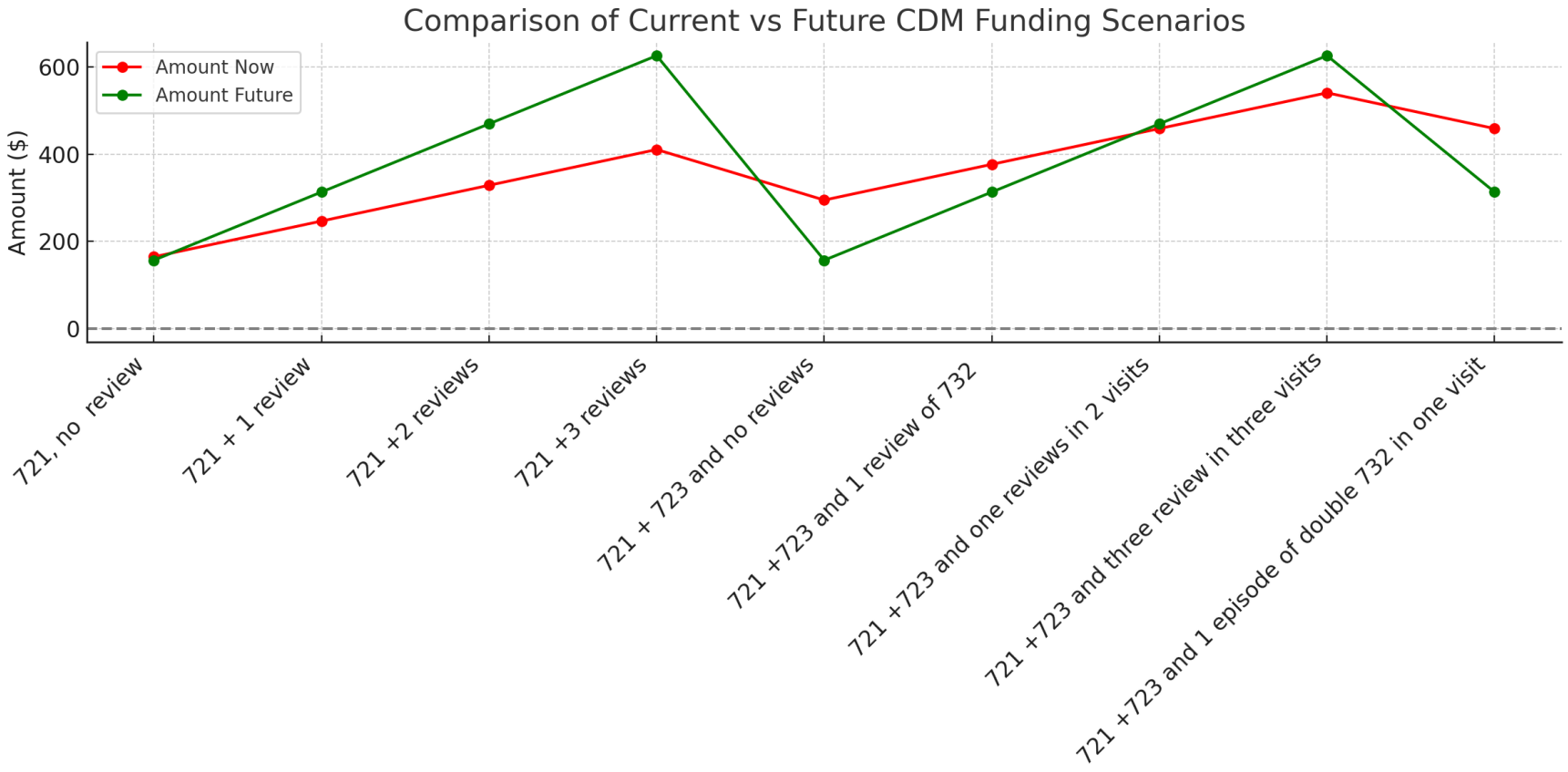
Not every patient needs a TCA and not every patient needs a double review

What is the value of time wasted with red tape? GP time? Nurse time? Admin time?

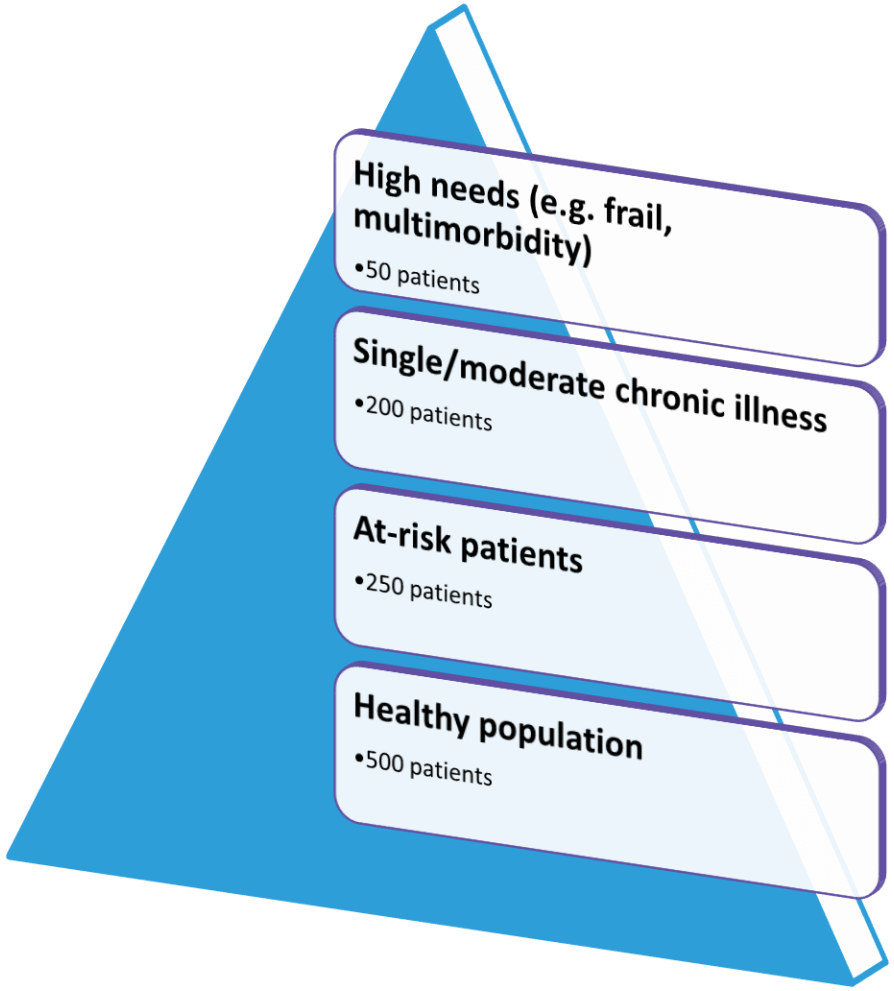
How many more patients can you all serve in that wasted time?

How do you use your team to improve care and use wasted time better?

Don’t forget TH (video)



The Population Health Pyramid



GP Chronic Condition Management Plan

Health Assessment for those eligible & Heart Health Checks

Case Conferencing

Home Medicines Reviews

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2

Practice in Action - General Practice Multidisciplinary Team-based Care and an Allied Health Perspective

Brooke Shelly & Dr Ryan Sheridan

What is a GP Pharmacist?

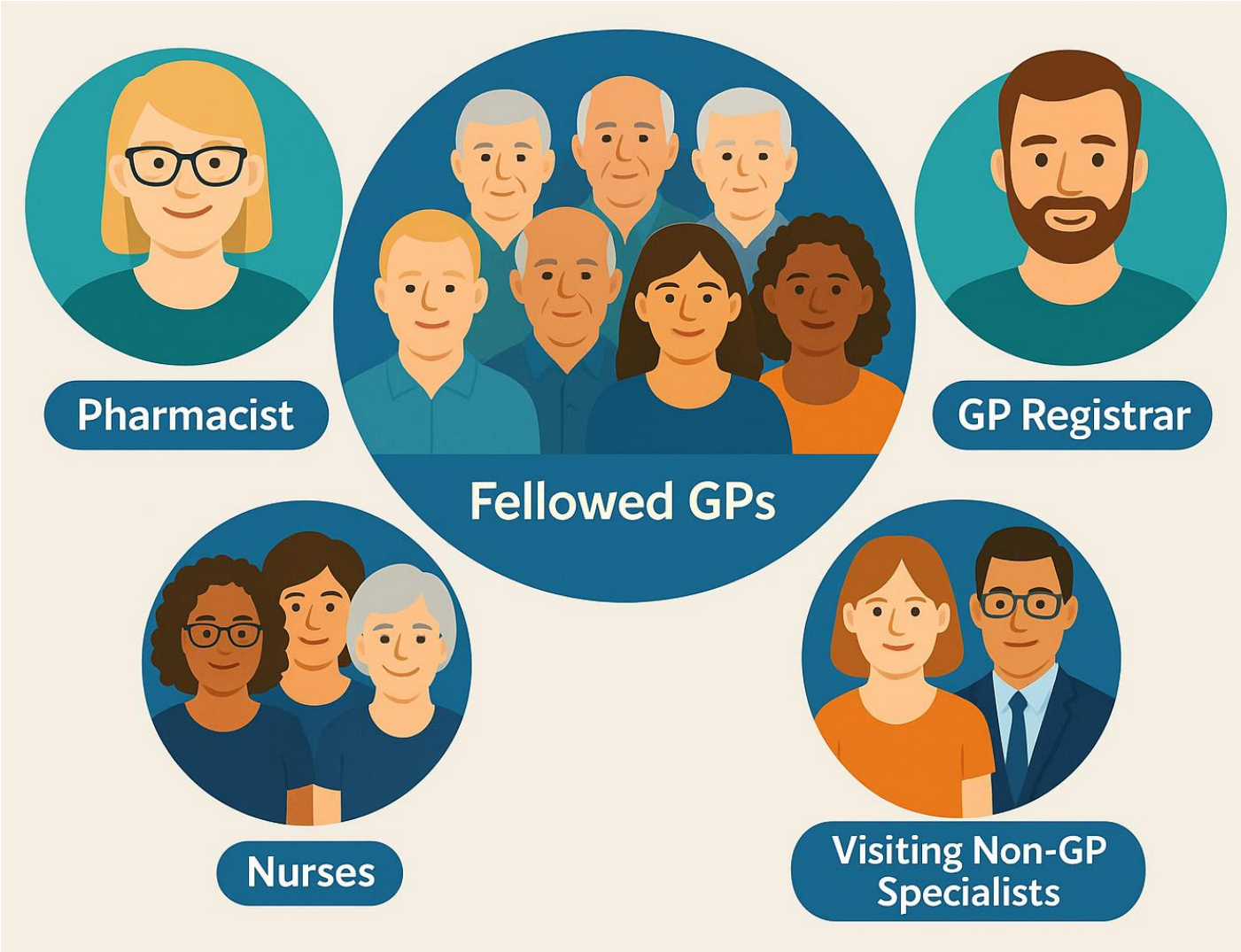
"GP Pharmacist" "On-site Pharmacist" "Embedded Pharmacist"

… just don't say "Clinical Pharmacist"

- **Medication optimization**
- **Transitions of care**
- **Deprescribing and quality use of medicines**
- **Case conferencing**
- **Medication education for the multidisciplinary team**
- **Training GP registrars**
- **Clinical meetings**

Better care starts with better teamwork

- Holistic, patient-centered, the patient is the Captain of the team
- No two MDTs will look the same- shaped by patient and community needs & skills matrix
- 92% of clinics have nurses
- 52% have AHPs services available
- No single HCP professional can meet all patient needs



Benefits of working in an MDT

- Holistic, patient centered care
- Better health outcomes
- Efficient use of resources
- Shared responsibility
- Improved communication
- Decrease costs due to reduction in duplication
- Stronger clinical governance
- Increased workforce satisfaction and retention
- Supports rural and remote care

Targeted deprescribing

Table 4. Prescriber barriers to deprescribing

Awareness	Inertia	Self-efficacy	Feasibility
Difficulty/inability to balance benefits and harms of therapy	Fear of unknown or negative consequences of change	Skill and knowledge gaps and deficits	Patient ambivalence or resistance to change
Inability to recognise adverse drug effects	Stopping is a lower priority issue	Reluctance to question a colleague's prescribing decisions	Poor patient acceptance of alternative therapies
Discrepant beliefs and practice	Stopping is difficult, futile, has/will fail	Incomplete clinical picture	Culture to prescribe more
Misconceptions	Belief that medicines work with few adverse effects	Pressure from aged care staff to continue prescribing	Limited time and effort to review and discontinue medicines
	Deference to professional etiquette/hierarchies	Lack of tools or resources to assist with deprescribing (or awareness of tools)	

Reference: Anderson et al[53], Scott et al[56]

Chronic Opioid Cycle of Care

- Structured approach to chronic pain & opioid prescribing
- Referral process for team-based care of complex pain management cases
- Opioid use disorder identification and management inc. case conferencing with addiction medicine specialist
- Deprescribing expectations set at time of prescribing

Barriers and Enablers to MDC

Category	Barriers	Enablers
Systems & Funding	- Fee-for-service model - Lack of funded time for interprofessional meetings and clinical governance - Workforce shortages in all areas - Legislation barriers to full scope	- Expanded and quarantined Workforce Incentive Program (WIP) - True blended or block funding models - Funding to support non-patient-facing team activities - Remove barriers to working to full scope
Team Integration	- Allied health professionals not always onsite (space/rooms availability) - Limited access to shared patient data and systems	- Support GP clinics to have AHP's onsite wherever possible - Enable virtual MDT participation with proper information and data sharing - Invest in interoperable digital health systems
Culture & Hierarchy	- Interprofessional politics (e.g. turf wars and hierarchy) - Unclear roles - Not understanding each others scope and skills	- Being "one team", working towards the patients shared goals - Promote a culture of shared decision-making and collaboration
Education & Training	- Minimal interprofessional learning at undergraduate level - Few structured training opportunities in team-based care	- Embed interprofessional education early in training - Provide ongoing professional development in collaborative practice

The 4 C's of MDT:
Clarity, Communication, Culture and Capability

Collaboration doesn't happen by chance – it happens when we value it, design for it and fund it.

True multidisciplinary care isn't a luxury for the future; it's a necessity for today.

3

Moving beyond teamwork

Dr Paresh Dawda

Experience
Financial
Outcomes
Inspiration
Team-based care
Story-telling
Value-based healthcare
Change management
Workforce
Population health
Journey
Challenges
Enablers

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Thinking about populations

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Integrated Practice Unit

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People Strategy

GP

Nurse Practitioners

Registered/ Enrolled Nurse

Patient advocate

Social Worker

Practice Pharmacist

Extended team

Geriatrician

Allied Health

Home Based Palliative Care

LDK

RADAR

Relational Strategy

Trust

- Culture & shared purpose
- Roles and responsibilities
- Communication
- Teamwork and teaming

Drivers for effective joint working

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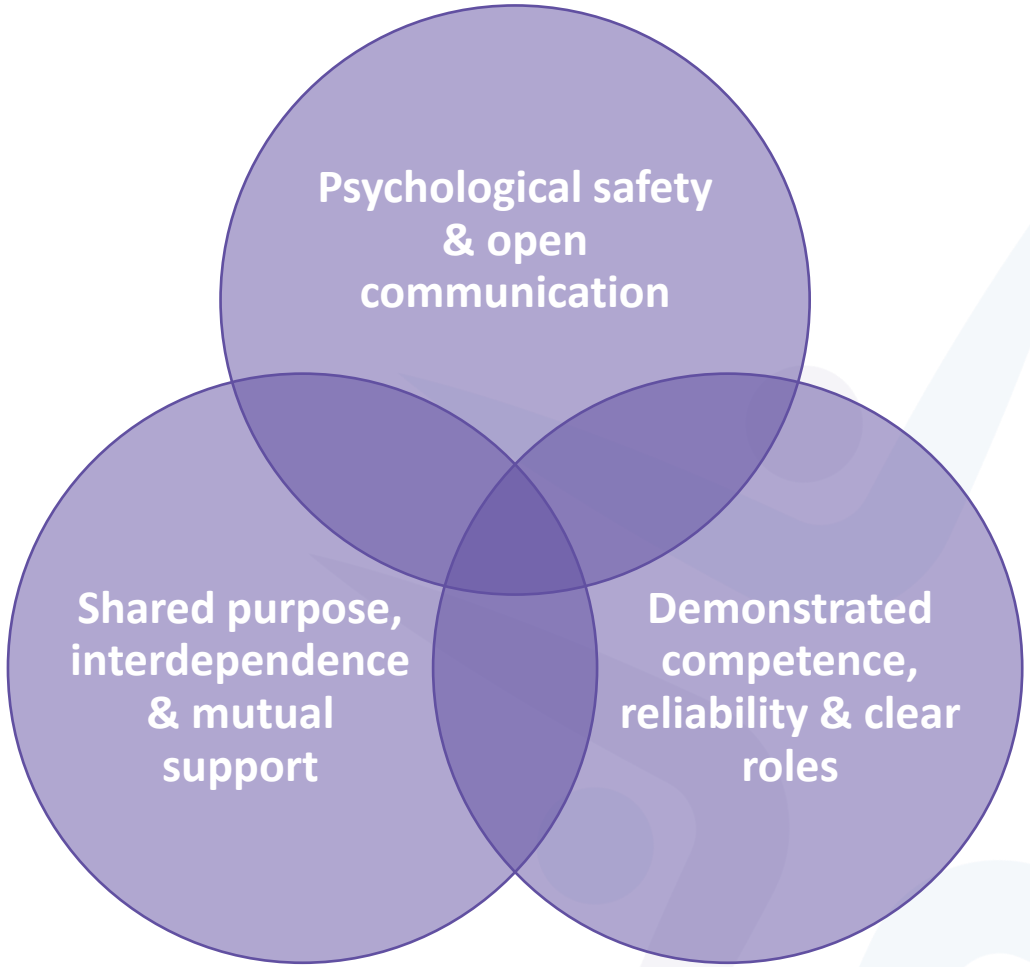
https://www.isc.hbs.edu/Documents/pdf/Porter_Lee_IPUs_NEJM_Catalyst.pdf

Three fundamental components of trust

Trust isn’t abstract

It is built through consistent behaviours that make colleagues:

- Feel ***safe***,
- Feel ***confident*** in each other’s abilities, and
- ***Aligned*** around a common purpose.



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Team rituals

Ritual	Purpose
Daily Huddle (10-15 mins)	Share key patient updates, prioritise care, flag risks or absence
Weekly Clinical Review Meeting	Discuss complex cases, review care plans, encourage reflective practice
Monthly Team Retrospective	Reflect on team functioning, barriers, improvements, and celebrate wins
Joint Care Planning Sessions	Collaborative development of care plans with patients and multiple providers
Team Lunches or Social Time	Foster psychological safety, relational trust, and morale
Welcome/onboarding rituals	Integrate new staff into team culture and workflows
Debrief after critical incidents	Support emotional wellbeing and continuous learning

Other Team Enablers / Structural Solutions

Category	Example Solutions
Communication Tools	Shared inbox, internal chat (e.g. Teams/Slack), secure messaging, care planning tools
Shared Documentation	Integrated EMR access, care planning dashboards, shared clinical notes
Defined Roles & Protocols	Role clarity, task delegation pathways, escalation processes, **standing orders**
Multidisciplinary Rounds	Structured reviews with clinicians, nurses, allied health and care coordinators
Team Agreements	Team charter, communication expectations, conflict resolution pathways
Leadership & Coordination	Dedicated care coordinator, team leader or clinical manager
Digital Enablement	Care coordination software, virtual whiteboards, shared task lists
Learning & Development	Team-based CPD, interprofessional education, joint case-based learning
Measurement & Feedback	Team dashboards, patient feedback, peer review, outcome tracking
Psychological Safety	Open-door policies, inclusive decision-making, leader modelling vulnerability

Team based care

Teamwork

is a **collaborative approach** in which a stable group of individuals, each with **defined roles and responsibilities**, works together to achieve a **shared goal**.

Teaming

is a dynamic approach to collaboration in which individuals quickly come together, often across disciplines, to address immediate needs or solve complex problems

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Traditional Teamwork vs. Teaming in Primary Healthcare

Aspect	Traditional Teamwork	Teaming
Team Structure	Stable teams with consistent members, often formal and hierarchical	Flexible, fluid , dynamic teams assembled as needed
Roles	Defined roles and responsibilities	Fluid roles based on expertise and situational need
Communication	Routine and planned interactions	Real-time, adaptive communication
Goal Setting	Fixed goals, often long-term	Adaptable goals that evolve with patient needs
Adaptability and training	Limited flexibility to change structure Periodic training	High flexibility, with rapid adjustments to demands Continuous learning embedded in work

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Team based care

Multidisciplinary Team Based Care

is a **collaborative** approach in which professionals from different disciplines work together, each contributing their unique expertise, to achieve a **shared goal**, typically related to patient care.

Integrated Practice Units

are **care delivery structures** where multidisciplinary teams work collaboratively and cohesively around a specific patient population or medical condition with like need.

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Multidisciplinary Teams and Integrated Practice Units

Aspect	Multidisciplinary Teams	Integrated Practice Units
Core Focus	Each discipline contributes to care from their own perspective, often focusing on individual aspects of the patient's needs.	Holistic, patient-centered approach that manages the entire cycle of care for a specific condition or population.
Structure	Professionals maintain distinct roles, collaborating through structured communication but often working in separate locations.	Co-located or closely aligned team working in a unified, integrated manner with a shared mission and workflows.
Communication	Structured, often periodic meetings to coordinate patient care.	Continuous and real-time communication within a team, facilitating coordinated and timely responses.
Responsibility	Responsibilities are divided by specialty, with each member focusing on their expertise.	Shared responsibility for the entire patient journey, aiming for cohesive, outcome-focused care.
Outcome Orientation	Focused on effective, discipline-specific interventions that contribute to overall patient care.	Outcomes-driven, aiming to improve overall patient experience, health outcomes, and resource use.

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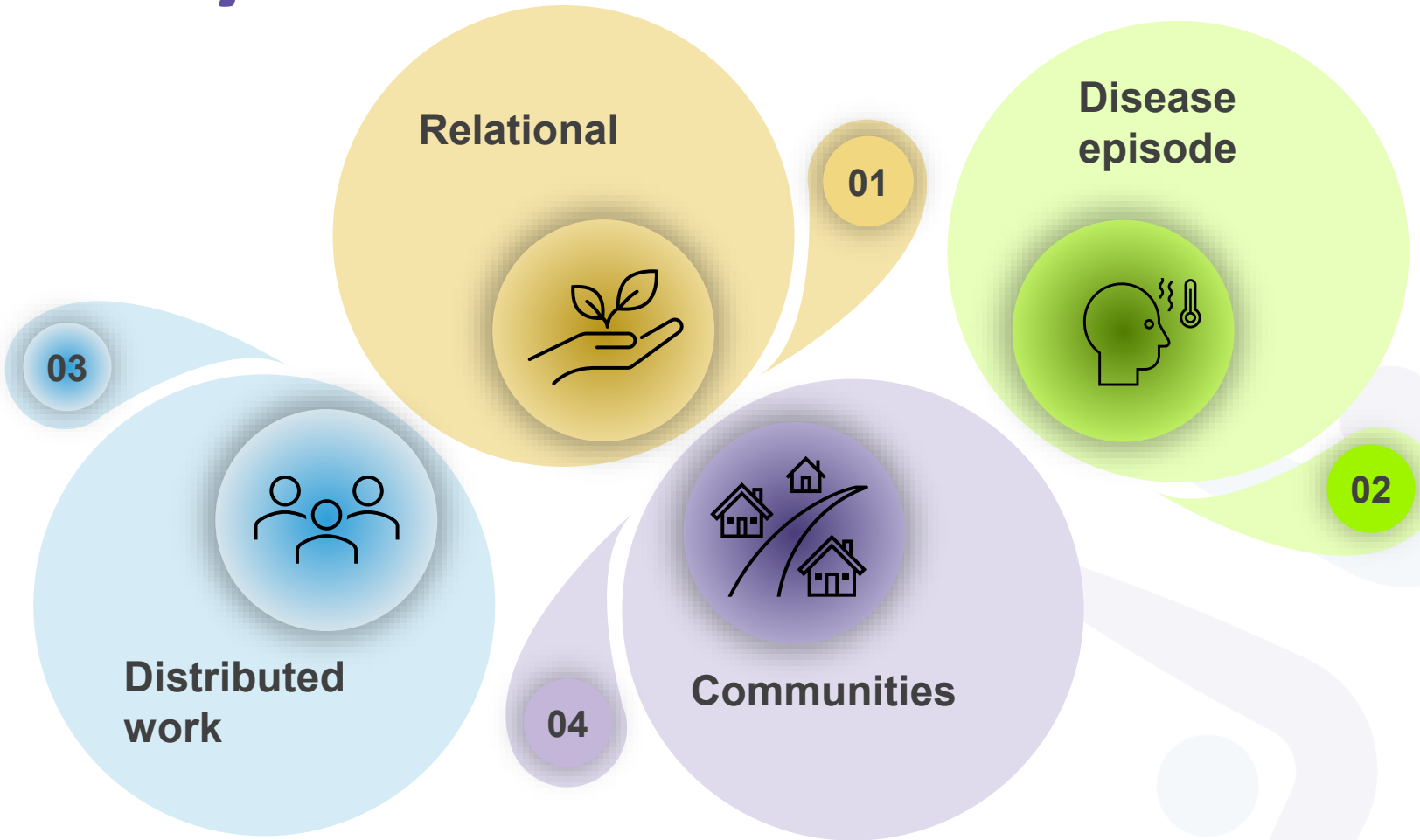
From	To
Care organised around **individual providers**	Care organised around the **patient's needs and goals**, supported by a **team**
Co-location of services without integration	**Integrated Practice Units** with shared purpose, shared care plans, and measurable outcomes
Team membership defined by **titles and scopes**	Teaming as a **dynamic process** – flexible, responsive, and outcome-focused
Focus on **clinical diagnoses and billing codes**	Focus on **functional goals, quality of life, and what matters to the patient**
Patient receives **disconnected services** across sectors	Patient receives **seamless, coordinated care** – even across NDIS, PHNs, Aged Care etc.
Technology as a **record-keeping tool**	Technology as an **enabler of collaboration, communication, and shared care**
One-size-fits-all care plans done for compliance	**Personalised care plans** developed with the whole team, including the patient
Informal, **ad-hoc communication** between team members	**Structured team rituals** – case conferences, huddles, care reviews
Measuring **activity** (visits, procedures)	Measuring **value** (outcomes achieved, patient-reported improvements, avoided harm)
System-centred care	**Human-centred, relational care** built on trust, continuity, and shared accountability

Continuity of care



Source: Ladds E, Greenhalgh T. Modernising continuity: a new conceptual framework. Br J Gen Pract. 2023 May 25;73(731):246-248. doi: 10.3399/bjgp23X732897. PMID: 37230773; PMCID: PMC10229150.

Implications of a non-co-located Teams in Primary Care

1. Increased reliance on digital infrastructure
2. Structured communication is critical
3. Shared purpose and goals must be explicit
4. Trust and psychological safety need to be cultivated deliberately
5. More complex governance and accountability structures
6. Risk of fragmentation without proactive integration
7. Greater emphasis on patient activation and self-management
8. Training and team development must be purposeful
9. Care coordination roles become central
10. Data sharing and interoperability are non-negotiable

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“Transformation is not a single moment of change but an ongoing commitment to improving processes, outcomes, and experiences in healthcare”
Atul Gawande
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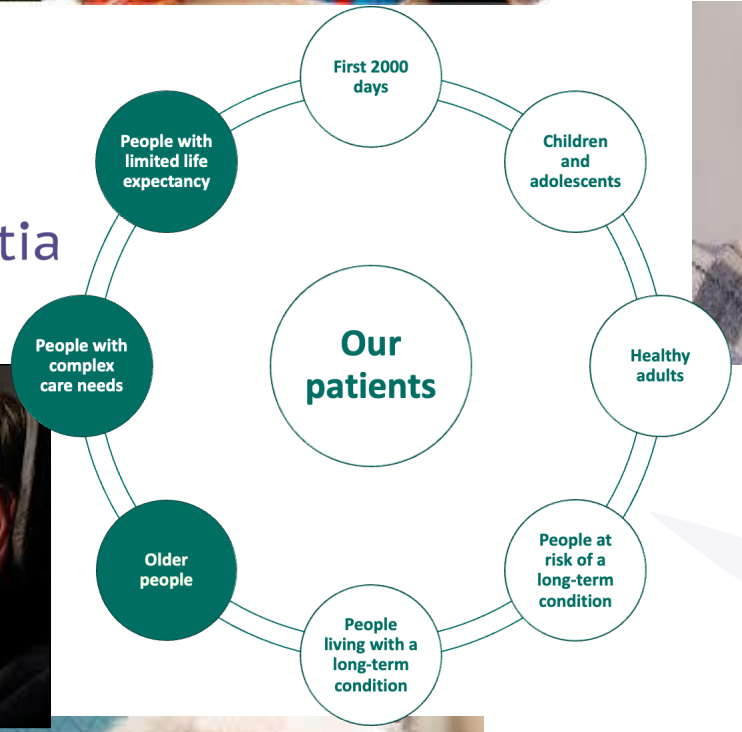

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Session Conclusion

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https://nwmphn.org.au/resources-events/resources/