Submission No 42

THE IMPLEMENTATION OF PORTFOLIO COMMITTEE NO. 2 RECOMMENDATIONS RELATING TO THE DELIVERY OF SPECIFIC HEALTH SERVICES AND SPECIALIST CARE IN REMOTE, RURAL AND REGIONAL NSW

Organisation: NSW Rural Doctors Network (RDN)

Date Received: 26 April 2024

RURAL DOCTORS NETWORK

26 April 2024

Dr Joe McGirr, MP
Chair, Legislative Assembly Select Committee on Remote, Rural and Regional Health
Via email: remoteruralregionalhealth@parliament.nsw.gov.au

Dear Dr McGirr

Inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW

Thank you for your correspondence (23 February 2024) and the invitation to provide a submission to the *Inquiry into the implementation of Portfolio Committee No. 2 recommendations relating to the delivery of specific health services and specialist care in remote, rural and regional NSW (SC Inquiry)*.

Rural Doctors Network (RDN) is an independent not-for-profit, non-government charitable organisation that has been in operation for over 35 years. The charity's purpose is to improve access to health and social services for remote, rural, regional and disadvantaged communities.

For disclosure, RDN receives funding from the NSW Government for delivery of programs related to the scope of the *Portfolio Committee No.2 Inquiry into Health outcomes and access to health and hospital services in rural, regional and remote New South Wales* (Rural Health Inquiry). The organisation also receives funding the Australian Government and acts as the Australian Government's designated Rural Workforce Agency for health in NSW.

I also acknowledge that in October 2023 I was appointed by Minister Park to chair the Regional Health Ministerial Advisory Panel through to 31 July 2023. In addition, members of RDN's Board, staff and contracted medical and clinical panel hold positions on various NSW Health committees.

Please see attached the RDN submission. I also take this opportunity to offer an in-depth briefing on the Collaborative Care for Remote and Rural Communities program, which features application of RDN's Community Solutions methodology within the five rural NSW trial sites since 2020. A program summary is included in this submission.

RDN thanks the Parliament of NSW for its continued interest in the welfare of NSW's remote, rural and regional communities.

Yours sincerely,
Richard Colbran PhD
Chief Executive Officer

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Rural Doctors Network activities are financially supported by the Australian and NSW governments

Rural Doctors Network's response to the Committee's Terms of Reference

Rural Doctors Network (RDN) would like to acknowledge the progress that has been made in relation to implementation of the Rural Health Inquiry recommendations, since their release in May 2022.

This progress includes work with RDN on various initiatives, in addition to those already delivered by RDN under NSW Health-funding, aimed at addressing a number of the Rural Health Inquiry recommendations. These additional initiatives include:

- Trial expansion of the NSW Rural Resident Medical Cadetship Program
- Wellbeing and fatigue initiatives for the rural health workforce, leveraging RDN's Rural Health Pro platform
- Health and health system awareness, understanding and engagement projects within rural NSW regions
- Rural Generalist and advanced skills demand and supply mapping project
- Expansion of RDN's Collaborative Care methodology pilots into additional rural NSW locations. See Appendix A for a summary of this methodology.

As an organisation that exists to improve health care access for rural, regional and remote communities, RDN measures its impact against six health access pillars, described below. These pillars will be identifiable in relation to RDN work referenced throughout this submission.

RDN's Health Access Impact and Transformation Pillars ©

Pillar	*Rationale*	*Objective*
Community	Communities engaged and participating in health and social care policy, design and delivery enhances health access	- Increased engagement of local community leaders and influencers in health solutions. - Introduction of localised data to inform and encourage locally-based co-design and provider social accountability.
Workforce	Health and social care workforce demonstrating higher self-reported whole-of-life capability deliver higher quality of care and are retained in rural practice longer	- Increased available pool of appropriately trained workforce. - Increased workforce capability.
Health Businesses	Improved capability of health businesses drives higher performance, sustainability, social impact plus creates more positive workforce and care environments.	- Increased health business performance, capability and social accountability. - Increased investment in remote and rural health businesses.
Service Models	Purposeful patient-centred team-based service arrangements that maximise scope of practice are vital for improved health access.	- Demonstrated supporting evidence of team-based service models. - Implementation and scaling of evidence-informed team-based service models.
Health Systems & Infrastructure	Ensuring remote and rural communities are supported with system design and infrastructure that enables health access in future and are not left behind metropolitan equivalents.	- Demonstrated design and delivery of systems aligned with current evidence of future needs and technologies.
Policy	Instigation and embedding of evidence-based system-wide policy and accountabilities aligned with future needs and technologies.	- Demonstrated change in national and state health policy to enable factors that enhance health access.

1) The delivery of specific health services and specialist care in remote, rural and regional New South Wales, including:

a) Maternity services, obstetrics and paediatrics (including Recommendations 19, 20, 26 and 27)

RDN notes that there is an urgent need to stem the ongoing loss of maternity and obstetrics services, and then to rebuild these services, in rural areas of NSW. Obstetric and maternity care close to a woman's residence means continuity of care and wrap-around care, throughout the antenatal, birth, and into the postnatal, period, in addition to undisrupted social support networks. This is of particular importance for Aboriginal women, who live in higher percentages in rural areas of NSW, in order to access culturally safe Birthing on Country models of obstetric and midwifery care. All of these service model aspects have demonstrated better outcomes for women and babies[1].

Maternity service closures began in Australia in 1980s and have continued since. Between 1990 and 2015, 47% of Australian birthing services closed[2]. The majority of these were small services (less than 500 births/year) in rural and remote locations[2]. Evidence indicates that these services are at least as safe as larger maternity services[1].

RDN notes the Australian Government's recent repeal of collaborative arrangement requirements for midwives[3], along with the earlier extension of professional indemnity insurance cover for privately practicing midwifes to deliver antenatal and postnatal care. Both of these are welcomed as essential enablers for rural access to maternity care, and continuity of this care, particularly for Birthing on Country models.

As mentioned in RDN's response to the Rural Health Inquiry, maintenance of an appropriately skilled, and rurally distributed, workforce is another essential element for continuity of these services. As such, RDN also acknowledges the Australian Government's introduction of the Workforce Incentive Program – Rural Advanced Skills Stream. This stream provides a financial incentive for doctors to develop advanced skills, including in obstetrics, paediatrics, and First Nations health, and also practice these skills in a rural location. As per the other WIP streams, this incentive will be administered by RDN within NSW and the ACT.

Acknowledging this progress, substantial and sustainable improvements in access to these services in rural areas will require a multifaceted approach, with commitment from stakeholders across both state and federal areas of the system. This commitment must include prioritisation from LHDs and funding from state and federal budgets, in order to change the tide in areas such as: development of innovative, integrated service models in those areas where local needs cannot support a more traditionally staffed service; engagement with local community and stakeholders when designing these services; creation of attractive, ongoing positions to staff these services; rebuilding of required infrastructure; and development on ongoing recruitment and retention supports responsive to workforce expectations.

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[1] Stewart, RA 2021, 'Birthing: A vital service for rural communities Perspectives from the National Rural Health Commissioner', *Australian and New Zealand Journal of Obstetrics and Gynaecology*, vol. 61, no. 5, pp. 647–649, accessed 16 April 2024, < https://pubmed.ncbi.nlm.nih.gov/34655086/>.

[2] Australian Broadcasting Corporation 2023, *VIDEO: National Rural Health Commissioner says system is putting women and babies at risk*, web page, accessed 16 April 2024, < https://www.abc.net.au/news/2023-02-27/national-rural-health-commissioner-says-system-is/102030678?utm_campaign=abc_news_web&utm_content=link&utm_medium=content_shared&utm_source=abc_news_web >.

[3] Australian College of Midwives 2024, *Barriers to midwifery care removed: Legislation to repeal collaborative arrangements introduced into Federal Parliament*, accessed 16 April 2024, <https://midwives.org.au/Web/News-media-releases/Articles/2024/20_March/Barriers_to_midwifery_care.aspx>.

b) Patient transport and paramedicine (including Recommendations 3, 28 and 29)

Proximity of health services to a population's location is a key enabler for health access, and is related to RDN Health Access Pillars of *Community*, *Service Models*, and *Health Systems and Infrastructure*. Provision of non-emergency transport support for patients to access care is, at best, a proxy and should be seen as a permanent access solution for only the most specialised of care services.

Within this context, RDN acknowledges the ongoing progress that NSW Health has made in relation to these recommendations. This includes the review of the NSW Health Patient Transport Service and the review of, and increased funding for, the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAAS).

As an alternative model aimed at overcoming distance-to-care access barrier, RDN notes the success of the federally funded Outreach programs in rural NSW. The aim of these programs is to increase access to health services for rural and Aboriginal people through the delivery of local specialist clinics that reduce access barriers, including the requirement for patients to travel long distances.

Since 2003, RDN has collaborated with more than 60 partners and local organisations, to deliver these programs. Over 850 health practitioners, including specialists, nurses, midwives, allied health professionals and Aboriginal health practitioners are supported under the programs to deliver health services to more than 200 towns and Aboriginal communities whose populations would otherwise have to travel a long distance to access. Critically, two-thirds of these clinicians are rurally based, and many have decades of commitment to rural practice, a demonstration of the impact of this program in relation to rural workforce retention.

c) Indigenous health services (including Recommendations 23, 31, 32, 33, 34, 35 and 43)

RDN would like to acknowledge the significance of these recommendations, particularly in light of the 2020 National Agreement on Closing the Gap, the 2024 Productivity Commission's review of progress against this agreement, and the Close the Gap Campaign Report 2024. Progress in achieving the Closing the Gap targets, and also the achievement of the associated Rural Health Inquiry recommendations, will not be possible without genuine commitment from all government agencies, and government-funded organisations, to work with Indigenous-led organisations on the goals of Indigenous communities themselves.

Within the NSW Health context, it is essential that any and all work in this space engages with Aboriginal Health & Medical Research Council of NSW (AH&MRC) and the local Aboriginal Community Controlled Health Services (ACCHS), from inception. Placing these organisations, and the Indigenous communities they represent, at the centre of changes and initiatives, and empowering them to co-design and implement solutions, will best utilise their knowledge, networks, and infrastructure; maximise achievement of culturally safe and accessible health care; and achieve improvements in relation to self-determination for their communities.

Again, RDN would like to acknowledge, and thank, the DoHAC for entrusting RDN to administer the federally funded health Outreach programs in NSW and the ACT for over 20 years. Administration of these programs is an example of how a non-Indigenous organisation can work in consort with Aboriginal-led organisations (i.e. Aboriginal Community Controlled Health Services) to support these organisations to deliver community-designed

and community-managed care. The ultimate aim being the delivery of culturally safe, and therefore accessible, health services for Aboriginal communities in rural NSW.

The Outreach programs are highly successful due, in large part, to the community-driven nature of how they have been set up. Needs assessment, service design and service integration are place-based and community-driven, in consort with associated data and expertise. This enables the programs' services to be sustainable, as well as being flexible enough to respond to changing community needs.

RDN is also part of a collaborative, along with Indigenous Allied Health Australia (IAHA) and the National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners (NAATSIHWP), that will be administering the Puggy Hunter Memorial Scholarship Scheme (PHMSS) in mid-2024. This will mark the transition of the PHMSS to Aboriginal and Torres Strait Islander community control, and RDN is honoured to be invited to participate and assist these two very important Aboriginal and Torres Strait Islander community-controlled organisations.

Aboriginal and Torres Strait Islander self-determination will not be possible without mainstream services ensuring Aboriginal communities are fully engaged, from inception to evaluation. Closing the Gap Priority Reform Three is "systemic and structural transformation of mainstream government organisations to respond to the needs of Aboriginal and Torres Strait Islander people". RDN is very proud of its ongoing relationships with Aboriginal-led organisations and is committed to continuing to support the transition of services into Aboriginal and Torres Strait Islander community hands.

d) Mental health services, and drug and alcohol services (including Recommendation 11)

RDN supports a focus on the access to mental health and drug and alcohol services for rural communities. PHN health needs assessments have highlighted a need for mental health and drug and alcohol services across rural NSW, and RDN's 2023/24 Health Workforce Needs Assessment (unpublished report to DoHAC) has identified that additional GP training in these areas is required.

Based on skills needs within primary care, priority foci for the federally-funded, RDN-administered Health Workforce Scholarship Program in NSW include mental health and addiction management. To date, in the current financial year (1 July 2023 – 19 April 2024), RDN has provided financial support for 224 individual upskilling and CPD training opportunities in the areas of addiction management and mental health training for rural primary care clinicians in NSW, awarding a total of $445,880.

Mental health is also a priority area for the RDN-administered Outreach programs. Supported by Commonwealth funding, RDN works with communities to develop service models that address unmet health needs in priority areas and funds delivery of these services into underserved communities. This financial year, these programs have allocated a total of $2.3m to mental health services for underserved communities in NSW and the ACT. In the last 6 months of 2023 (1/7/23 - 30/12/23) these programs delivered 579 mental health clinics, utilising psychiatry (including sub specialities), psychology, nursing, Aboriginal Health Worker, and social worker craft groups. These clinics delivered 4745 occasions of service, of which 3078 (65%) were for First Nations People. Unfortunately these programs operate within a finite budget and contractual timeframes, which limits their ability to meet all unmet needs in the programs' priority areas.

RDN supports the Rural Health Inquiry's call for a 10-Year Rural and Remote Medical and Health Workforce Recruitment and Retention Strategy. Development of plans and solutions

specifically for rural communities, such as those called for in recommendation 11 of the Rural Health Inquiry, will ultimately deliver best care for these communities. The often-applied approach of redesigning metropolitan solutions for rural application is not indicated as the most effective, efficient or sustainable approach[4]. This is also in alignment with RDN's Health Access Impact Pillars of *Community* and *Health Systems & Infrastructure*.

e) Aged care and palliative care (including Recommendations 18, 23 and 24)

RDN notes the difficulties in maintaining clinical staff with relevant specialist skillsets in rural areas, including those with aged and palliative care skills[5]. It is imperative that these clinical skills are available in rural areas due to the larger proportion of aged people within these populations[6], an increasing population-level demand for these services[7], and best-practice delivery of these services being close to people's homes[7,8]. It is imperative from a system manager point of view, as there is evidence that such services provide system cost savings overall[9].

In efforts to improve rural access to these services, policy and system designers must ensure Aboriginal and Torres Strait Islander governance, knowledge and co-design is embedded within any system changes, from inception to implementation, and ultimately ongoing management. Indigenous people are represented in high percentages in both rural communities and the clinician workforce servicing these communities. Learning from, and designing for, these communities and workforces is imperative to achieving genuine, ongoing self-determination.

RDN notes that residential aged care services are delivered by NSW Health multipurpose services (MPS) in many rural communities throughout NSW. Within this context, RDN commends the NSW Health's Agency for Clinical Innovation's (ACI) Rural Health Network's development of the Living Well in MPS resources[10], designed to assist staff in providing care for MPS residents, not as patients in hospital, but as people living in their home. RDN is proud to be a member of the ACI's Rural Health Network Executive Committee.

RDN also notes that the DoHAC's Workforce Incentive Program – Rural Advanced Skills Stream (mentioned previously) includes incentive payments for advanced skills in the area of palliative care, but not in aged care. Inclusion of aged care advanced skills in this program would be beneficial.

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[4] Lyle, D, Saurman, E, Kirby, S, Jones, D, Humphreys, J & Wakerman, J 2017, 'What do evaluations tell us about implementing new models in rural and remote primary health care? Findings from a narrative analysis of seven service evaluations conducted by an Australian Centre of Research Excellence', *Rural and Remote Health*, vol. 17, no. 3, p. 3926, accessed 17 April 2024, <https://pubmed.ncbi.nlm.nih.gov/28877588/>.

[5] Australia New Zealand Society of Palliative Medicine, 2024, *Beyond the Burbs: Specialist Palliative Medicine Training in Rural Australia – A Scoping Review*, accessed 17 April 2024, <https://www.anzspm.org.au/common/Uploaded%20files/RRPIM/RRIPM_Scoping_Review_FINAL.pdf>.

[6] Australian Institute of Health and Welfare (AIHW) 2023, *Older Australians*, accessed 26 March 2024, <https://www.aihw.gov.au/reports/older-people/older-australians>.

[7] Australian Government Department of Health and Aged Care, 2019, *The National Palliative Care Strategy 2018*. [online] Available at: https://www.health.gov.au/resources/publications/the-national-palliative-care-strategy-2018?language=en.

[8] Aabom, B, Kragstrup, J, Vondeling, H, Bakketeig, LS, Stovring, H, 2006, 'Does persistent involvement by the GP improve palliative care at home for end-stage cancer patients?', *Palliative Medicine,* vol. 20, no 5, p.507-512, accessed 18 April 2024, doi:10.1191/0269216306pm1169oa

[9] Palliative Care Australia, KPMG, 2020, *Investing to save: The economics of increased investment in palliative care in Australia*, accessed 17 April 2024, <https://palliativecare.org.au/download/20649/>.

[10] Agency for Clinical Innovation, 2016, *Living well in multipurpose services*, accessed 17 April 2024, <https://aci.health.nsw.gov.au/networks/rural-health/resources/living-well-in-multipurpose-services>.

f) Cancer care and oncology (including Recommendation 21 and 30)

RDN supports the Rural Health Inquiry recommendations 21 and 30. RDN notes that most specialist oncology care is provided in metropolitan and large regional centres. RDN also notes that continuity of care for oncology patients is best achieved by coordination of this care by the patients' primary care provider.

Utilisation of technology, including telehealth, to achieve this continuity and coordination of care, is noted as an approach to improving care for rural patients in this specialist area. RDN notes NSW Health's ongoing implementation of their Virtual Care Strategy 2021-26 in relation to provision of access to specialist care, and associated work in improving care for rural oncology patients.

g) Other specialist care and allied health services, as they pertain to the Portfolio Committee No. 2 recommendations (including Recommendations 5, 10, 30, 42, 43, 44)

RDN strongly supports place-based methodologies for addressing healthcare access issues, particularly those in rural areas. Evidence indicates that community-based development and, subsequently, community-led management of these solutions is effective in creating sustained improvement in community health outcomes, particularly when backed by strong organisational and community processes[11,12].

RDN has a long history of sustained community engagement and place-based approaches to healthcare access solutions. Development of our town-based planning approach into our current Collaborative Care© methodology[13] is evidence of the maturity of RDN's methods in this space. Five NSW pilots of this methodology are currently being funded by the Australian Government (through Innovative Models of Care grants). More recently the NSW Government has indicated intention to fund additional NSW pilot sites of this methodology, as part of their response to Rural Health Inquiry recommendation 10. RDN is heartened to see this commitment to, not just, place-based solution development, but also development of rural solutions for rural communities.

In addition to the Collaborative Care pilots, NSW Health has also funded RDN to work with Local Councils to improve their ability to engage with their communities to support health access and health workforce attraction and retention. This project is currently being conducted with 11 rural local councils within central NSW. RDN is supporting these Councils via facilitation and engagement of health stakeholders relevant to each Local Government Area, and development of bespoke analyses providing information on health status, health access, and attraction and retention of health workforce within each.

This program has been designed to strengthen local government strategic regional capability, delivery of regional priorities, and ensure investment is aligned to evidence and is enabling the best outcomes for community. It is anticipated that through development of these networks and provision of these analyses to local councils, communities will be

[11] Vargas C, Whelan J, Brimblecombe J, Allender S, 2022, 'Co-creation, co-design and co-production for public health: a perspective on definitions and distinctions'. *Public Health Res Pract*, vol. 32, no. 2, accessed 27 March 2024, <https://doi.org/10.17061/phrp3222211>.

[12] Haldane V, Chuah FLH, Srivastava A, et al. 2019, 'Community participation in health services development, implementation, and evaluation: A systematic review of empowerment, health, community, and process outcomes'. *PLoS ONE*, vol. 14, no. 5, accessed 27 March 2024, <https://doi.org/10.1371/journal.pone.0216112>.

[13] Ramsden R, Davies S, Colbran R, et al. 2021, 'Collaborative care: Primary health workforce and service delivery in Western New South Wales—A case study'. *Aust J Rural Health*, vol. 29, no. 5, accessed 27 March 2024, <https://doi.org/10.1111/ajr.12796>.

enabled to better participate and drive locally based solutions in partnership with local, state and federal stakeholders.

2) Any updates or further observations relating to the progress of implementing Portfolio Committee No. 2 recommendations relating to workforce issues, workplace culture and funding issues, as per the Select Committee on Remote, Rural and Regional Health's previous inquiry

There has been increased attention on rural health over the past two years since the Rural Health Inquiry and notable investment from NSW Health in response to these recommendations. RDN looks forward to the subsequent Parliamentary Committee No.2 Inquiry into implementation of these recommendations, two years from their initial release, as committed to under recommendation 6 of the Rural Health Inquiry.

Despite this progress, there is still much to be done. One area of improvement that RDN would like to suggest is an improved focus on rural training pathways for all non-GP specialist trainees. Implementation of such pathways will realise rewards in two areas: an increase in rurally located non-GP specialists; and improved specialist skillsets in relation to rural and remote health needs and understanding of the rural and remote context and service requirements.

Apart from the Australian Government's Specialist Training Program, progress has been slow. There is a need for commitment from all stakeholders, including a directive focus from both state and federal governments. RDN supports the AMA's position statement, Rural training pathways for specialists[14], and commends this for this Inquiry's attention.

[14] Australian Medical Association, 2020, *AMA Position Statement: Rural training pathways for specialists*, accessed 27 March 2024, <https://www.ama.com.au/position-statement/rural-training-pathways-specialists-2020#:~:text=The%20purpose%20of%20this%20position,must%20be%20identified%20and%20addressed>.

Appendix A – Collaborative Care© Methodology

The Collaborative Care Program has been developed by RDN as a community-centred approach to addressing the primary health care challenges in remote and rural communities. These challenges include community access to appropriate care, the recruitment and retention of health practitioners, and the financial sustainability of health services.

The Program works with local health professionals and communities to create a primary healthcare model that fits their needs. It does this by bringing local stakeholders together using a proven methodology to develop shared priorities and solutions to trial. The Collaborative Care Program is an extension of RDN's town-based health planning approach which has proven successful for more than 30 years.

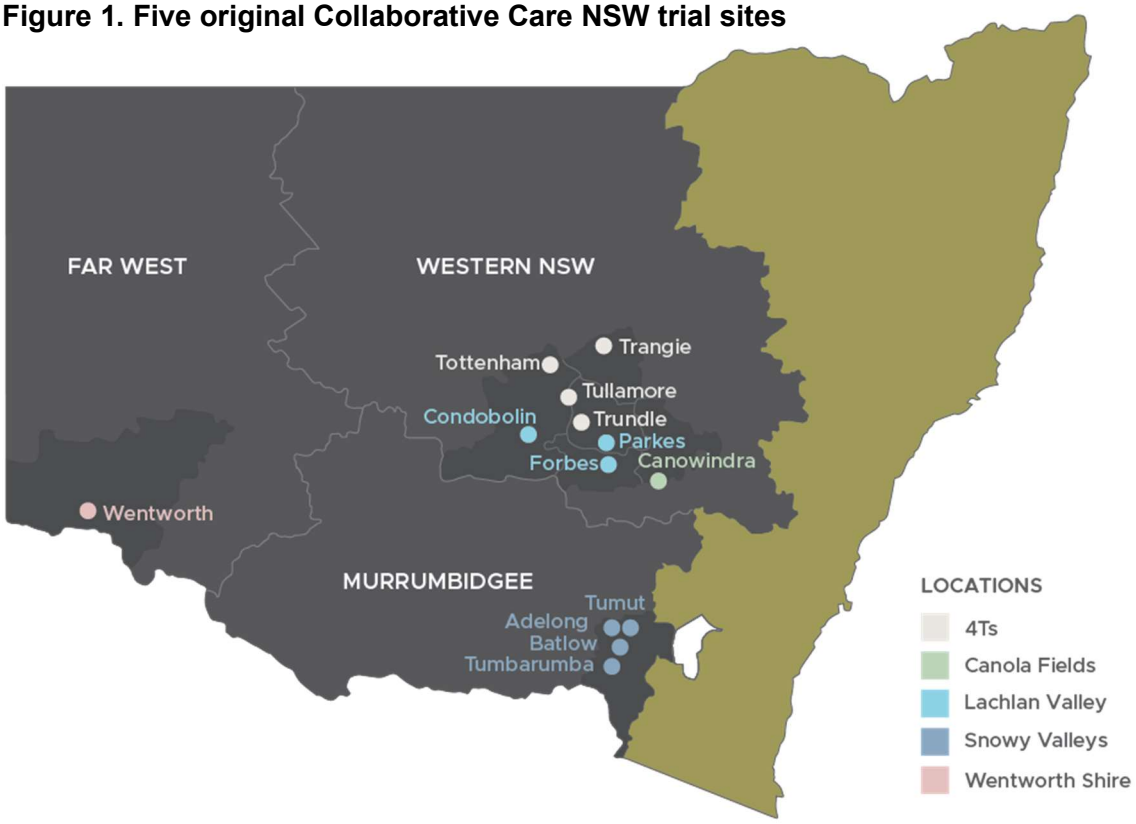
The original Program was applied to five trial sites in rural NSW, with funding support from the Australian Government Department of Health and Aged Care (DoHAC). This funding is scheduled to run until June 2024, with most of the trials are now completed and undergoing evaluation. The models created and implemented under the Program in these five sites have transitioned their activities to business as usual.

The Program tested unique models of primary healthcare service delivery in five locations across rural NSW (see Figure 1):

1. The 4Ts (Tottenham, Tullamore, Trangie, and Trundle)
2. Canola Fields (Canowindra and surrounding towns)
3. Lachlan Health Region (Condobolin, Forbes, and Parkes)
4. Snowy Valleys (towns of the Snowy Valleys LGA)
5. Wentworth Shire.

Since 2023, RDN has been working closely with the NSW Ministry of Health to identify new trial sites for the Collaborative Care Program.

Figure 1. Five original Collaborative Care NSW trial sites



Who is involved?

The Collaborative Care Program is the result of an ongoing collaboration between RDN and our partner agencies that cooperatively administer these projects:

- Far West Local Health District
- Murrumbidgee Local Health District
- Western NSW Local Health District
- Murrumbidgee Primary Health Network
- Western NSW Primary Health Network.

In each location, we also work with many other local representatives to achieve a holistic, community-centred approach. The Program is coordinated by RDN utilising funding support from the DoHAC.

How does it work?

The Collaborative Care Program uses a staged approach to place-based primary healthcare planning. The coordinating organisations form a project team that guides their communities through the following five steps (and in Figure 2):

1. Investigate needs: what are the primary health care needs in the community?
2. Prioritise needs: which of these needs should we tackle first?
3. Co-design solutions: decide together how we could improve access to these important services for the community.
4. Implement solutions: put the plan into practice and make sure communities know what to expect.
5. Reflect & learn: look at what is working well and where improvements can still be made.

In practice, it is an iterative process rather than five linear steps as depicted in Figure 2. As the stakeholders continue to collaborate, they uncover more opportunities to improve access to primary healthcare in their communities. The learnings from previous activities lead to new investigations, new opportunities, and new solutions to be trialled.

Community engagement and empowerment are central to each step and essential for solutions to be effective. Through the five trials, RDN also identified several key enablers depicted on the outer ring of the diagram. These enablers must be in place for the process to work effectively. If some of the enablers are missing the process will undertake specific activities to address them.

This process was developed and codified by RDN's Collaborative Care team from learned experience in facilitating the five trial sites between 2021-24. A range of tools were also developed to support project teams in navigating each of the steps.

Figure 2. Collaborative Care© Process