Chronic Conditions Management

General Practice Activation Series

phn NORTHERN QUEENSLAND
An Australian Government Initiative

Activity 1: New Year CDM resolutions

It's time to prepare your general practice for changes to Chronic Conditions Management (CCM) MBS items. Chronic Conditions Management (CCM) MBS item changes recommended by the MBS Review Taskforce are 'the first major change to chronic disease management in 20 years, and are scheduled to come into effect 1 July 2025'.

Change is a dish best served in small, manageable bites! Australian general practices are well versed in continuous quality improvement methods and Plan – Do – Study – Act cycles that support change in busy environments, safely and sustainably whilst measuring results.

To help your practice prepare to transition to CCM with small, manageable changes, Northern Queensland Primary Health Network (NQPHN) invites your practice to participate in our CCM activation series of high impact change activities with your practice team and patients to implement new chronic conditions management items, strengthening the connections that patients have with your practice through MyMedicare.

To get started, Activity 1 aims to engage patients returning to your practice for Chronic Disease Management Plans and team care arrangements in MyMedicare, and regular reviews in the future.

The next activity in the series will be released in February 2025 (Activity 2) and will aim to raise awareness among your practice team of MyMedicare, Chronic Conditions Management changes, and support your team to explore their roles in both MyMedicare and Chronic Conditions Management.

We look forward to supporting you through this CCM activation series!

Activity outcomes

1) Register all returning Chronic Disease Management Patients for MyMedicare with your practice prior to, or at their next Chronic Disease Management appointment.
2) Develop a process for booking future review appointments for any patient you put onto a Chronic Disease Management Plan.
3) Develop a clear communication for why review appointments are important to attend for your practice team and patients (including if there are out of pocket costs for the patient).
4) Develop a process to manage missed or cancelled patient review appointments.

NQPHN funded activities

- MyMedicare Mini Continuous Quality Improvement fully funded GoShare packages.
- Primary Sense reports to assist with identifying eligible and managing workflows.
- INCA fully funded shared care platform to simplify CCM.
- Primary Care Engagement Team support resources and practices visits.
- GoShare and GoShare Voice recall and reminder packages for practices participating in the ProCCM program.

NQPHN acknowledges the Aboriginal and Torres Strait Islander peoples as Australia's First Nation Peoples and the Traditional Custodians of this land. We respect their continued connection to land and sea, country, kin, and community. We also pay our respect to their Elders past, present, and emerging as the custodians of knowledge and lore.

ISO 9001 QUALITY

Activity Ideas

1) Register all returning Chronic Disease Management Patients for MyMedicare with your practice prior to, or at their next Chronic Disease Management appointment.

a. Prompt your patients to register in advance of their appointments.

- **i.** Send an SMS to all patients with a scheduled Chronic Disease Management Plan encouraging them to register with your General Practice before their appointment using Medicare Online or print and complete a MyMedicare Registration form to bring to their appointment, or
- **ii.** Invite patients to attend their appointment early to complete a MyMedicare Registration Form in the practice waiting room.

b. Encourage your patients to register at their next appointment

- **i.** Check each patients' MyMedicare Registration status with your practice when they present for their appointment or the day before their appointment
- **ii.** Provide a MyMedicare Registration QR code or MyMedicare Registration form when patients present to the practice, and encourage them to complete their registration, or discuss registration as part of their Chronic Disease Management appointment
- **iii.** Have your practice nurse or Aboriginal Health Practitioner assist the patient with completing the registration for as part of their Chronic Disease appointment. This provides an opportunity for a conversation about expectations of an ongoing care relationship so that the practice can support the patient's health journey in the long term.

2) Review and strengthen your process for booking review appointments for any patient you put onto a Chronic Conditions Management Plan, or with an existing Chronic Disease Management Plan.

a. Consider and develop a method for how your practice will approach scheduling review appointments. You may decide to adopt a standard 3-month review or 6-month review approach or require the clinical team to advise on the review timelines informed by their clinical judgement on a case-by-case basis.

b. Develop workflows for reception – to ensure that as the patient is handed over to reception before they leave your practice reception has an action to schedule their next appointment, understands the timeframe for review to inform scheduling, and communicates the appointment time and date clearly to the patient (SMS, or reminder card, or other)

c. Develop a process for appointment reminders in leadup to review appointments – frequency (e.g. 1 week and 24 hours) and modality (phone call or SMS) to ensure your attendance rates for review appointments remain high. Include message for patient to check Medicare Online to ensure they are registered for MyMedicare with your practice, document any questions to bring to the appointment.

3) Review and strengthen communication for why review appointments are important to attend for your practice team and patients (including if there are out of pocket costs for the patient).

a. Review your process and strengthen how you document priorities and actions due for the next review appointment in the patients' medical record in your practice software as part of all Chronic Disease Management Plans and Reviews. For example, document any:

- **i.** Outcomes, goals or targets the patient has for their review appointment
- **ii.** Education or points of discussion planned for the review appointment
- **iii.** Tests or pathology due that need to be scheduled
- **iv.** Referrals that need to be completed

b. Communicate the importance of the review appointment with your patient and their carers (if appropriate) including:

- **i.** Emphasize the importance of the review plan focusing on actions for the patient and why the review is needed with your patient at the conclusion of the appointment
- **ii.** Provide patient with a printed copy of the care plan and review appointment plan
- **iii.** Outline expectations and processes to re-schedule review appointment ahead of time

c. Develop messaging for patients about the benefits of proactive care, care when you are not acutely unwell, or keeping you well. Develop communications to support this in your practice, for example:
   i. Waiting room posters targeting CDM patients
   ii. Talking points for the practice team to reinforce the importance of reviews and attending for care when patients are not acutely unwell.

4) Review and strengthen your process to manage missed or cancelled patient review appointments. Document the process for how to manage cancellations or missed review appointments. As part of this process consider:

a. How is the cancellation or non-attendance documented? For example, will your practice flag the patient, or retain a list of patients that need to be re-scheduled?
b. Who needs to be notified? (e.g. Nurse or Aboriginal Health Practitioner with responsibility for Chronic Disease coordination, and the patients usual GP)
c. What are the standing arrangements for re-scheduling CDM review appointments? For example, does your practice aim to re-schedule within 2 weeks of the cancellation or follow up non-attendance with a phone call to reschedule as a standard operating procedure?
d. Are there any data searches that need to be completed at regular intervals to identify any patients that may have missed their appointment but not been re-scheduled? For example, you could run a report from your clinical practice software for patients that have not had a review in more than 6 months and provide this list to a Nurse or Aboriginal Health Practitioner with responsibility for Chronic Disease coordination for review and action to check for any patients that have missed their scheduled review.

Step 4: Engage with your practice team to explore and document team roles and responsibilities related to MyMedicare and Chronic Conditions Management

Resources proposing some team roles ideas and a blank template are provided below to help you get started.

a. Explore roles and responsibilities with the practice team in a meeting or quick lunchtime discussions.
b. Document agreed roles and responsibilities and communicate this with your team.
c. Discuss and document how each team member will incorporate their responsibilities into their workday and work week.
d. Schedule a time to review your documented roles and responsibilities.
   i. Check in with your practice team four weeks after publishing these for a quick reflection and to maintain momentum as people adapt to their new responsibilities.
   ii. Review team roles and responsibilities at three months and make any changes or improvements based on lessons learned.

Further information

If you would like support from our team to implement this activity, please contact us at pce@nqphn.com.au

Stay tuned for Activity 2 which will focus on Planning with your practice team - awareness and practice team roles.

Cairns
p: (07) 4034 0300
Level 5, 111 Grafton Street
Cairns, Qld 4870

Townsville
p: (07) 4796 0400
Building 500, Level 3
1 James Cook Drive, Douglas, Qld 4814

Mackay
p: (07) 4963 4400
2/45 Victoria Street (Ground Floor)
Mackay, Qld 4740

e: pce@nqphn.com.au **w:** nqphn.com.au