Practice Nurse Networking Night

Wednesday 2 July 2025

phn GOLD COAST

An Australian Government Initiative

Acknowledgement to Country

Artist: NARELLE URQUHART, WIRADJURI WOMAN]

Gold Coast Primary Health Network would like to acknowledge and pay respect to the land and the traditional practices of the families of the Yugambeh Language Region of South East Queensland and their Elders past, present and emerging.

Housekeeping

Please switch mobile phones to silent during presentations

Rest Rooms

Evacuation procedure

GCPHN Update

Kellie Trigger
Director Health Intelligence Planning and Engagement

Gold Coast Primary Health Network

Immunisation Impact Grants

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Gold Coast Primary Health Network (GCPHN) is offering small grants of up to $10,000 to local primary care providers, medical organisations, and not-for-profit organisations within the GCPHN region. Funding must be **used to hold out-of-hours clinics targeting our vulnerable population,** with the aim of increasing immunisation rates and improving knowledge on the important benefits of immunisations within local communities. Out-of-hours-clinics **must be held between 1st August 2025 and 31st October 2025.**

Who can apply:

- Primary health care providers and medical organisations (i.e. general practices, local pharmacies – must be a QLD vaccine service provider)
- Not-for-profit organisations
- Community groups (i.e. support groups or associations)
- Individual health professionals (Individual applicants must be endorsed by employing organisation)

Immunisation Impact Grants Cont.

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Funding categories:

There are 3 funding categories available and eligible applicants can apply for multiple categories.

These include:

- Equipment Support (*short-term equipment hire*)
- Staffing and Operations (*staffing costs; wages, contracting staff*)
- Resources (*printing costs*)

SCAN HERE for more information

Applications close:

4.00pm, Friday 18 July 2025

- If you have read the guidelines and still have questions, please contact Carmen Dresser-Holmes at practicesupport@gcphn.com.au or 07 5612 5408 or please see one of the Engagement Officers in attendance tonight.

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Digital READINESS Assessment

Self-assessment tool designed to help general practices evaluate their current use of digital health technologies

Its purpose is to identify digital health use and needs in general practice, enabling GCPHN to provide more tailored support.

By completing the assessment, general practices will receive a personalised **digital health action plan** designed to support their unique priorities.

To acknowledge completion, GCPHN will provide practices with a **corporate-level CDM Plus licence**, including access to clinical templates, billing tools, flowcharts, and digital resources for chronic condition management.

Event – CDM Plus Chronic Conditions Management

Tuesday 15 – Wednesday 16 July 2025

Gold Coast Primary Health Network, in partnership with CDM Plus, invite Gold Coast general practice clinical staff to a two-day Chronic Conditions Management Workshop.

Day 1:
A comprehensive introduction to chronic condition management.
Practical tips and step by step on everything chronic condition management including:

- Medicare, using MBS online, keeping up to date with changes, CCM item numbers and MBS billing combinations
- Care plans and reviews
- Health assessments and allied health pathways
- Home Medicines Review (HMR)
- Case studies

Day 2:
Advanced chronic condition management including:

- Prevention, detection and management of chronic conditions such as asthma/COPD, diabetes, cancer, osteoporosis, cardiovascular disease and chronic kidney disease
- MBS item numbers for common detection and management activities
- Complex care and MBS billing pathways
- Data and reporting, quality improvement and digital health
- Case conferences
- Case studies

TO REGISTER SCAN THE QR CODE

SAVE THE DATE | Upcoming Events

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CDM Plus Chronic Conditions Management Two – Day Workshop

- **Tuesday 15 and Wednesday 16 July | 9:00am-4:00pm | GCPHN Offices**

CDM Plus Webinar

- **Tuesday 29 July | 12:30pm – 1:30pm | Online**

CDM Plus Webinar

- **Thursday 14 August| 6:00pm – 7:00pm | Online**

Benmarque Group Complex Immunisation Catch-Ups Workshop

- **Wednesday 20 August| 8:30am-11:30am | GCPHN Offices**

Benmarque Group Immunisation Support in Primary Healthcare

- **Wednesday 3 September| 9:00am-1:00pm | Online**

SCAN HERE for more information or to view the GCPHN Event Calendar

Practice detail collection

- We are transitioning to a new CRM
- Easier online process for updating practice details coming
- Transition period will be a little clunky
- Sorry for any inconvenience

Health Data and Data Linkage

Kellie Trigger
Director Health Intelligence Planning and Engagement

Gold Coast Primary Health Network

Growing Importance of Data

In Australia primary care and general practice in particular is often seen as the cornerstone of the healthcare system. Health information from primary care is used in two ways:

Primary purpose

- To better coordinate care and safety including across other providers who provide care to a patient (e.g. referral to a specialist)
- To support population health planning within a practice (recalling patients due for a health assessment)

Secondary purposes (more recently)

- Inform planning at a regional level
- Inform research to evaluate services or improve outcomes
- Combine with other data to inform planning and research (data linkage)

Is it on the radar for patients?

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Is use of the health information and data that is held in primary care something patients think about?

If so, what are their general thoughts/assumptions, questions or concerns?

Data Sharing and Linkage -
Is this something on the radar for health consumers?

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GCPHN CAC Feedback

DISCUSSION	Few people in everyday life actually looked at/read or thought about how data at general practice is collected and used. Initially, focus was on how they access their data for their own information, highlighting that information to patient and My Health Record is not working that well. Data use and privacy policies that seek patient consent to collect their information is often ignored/overlooked. Most people were happy to share their health data for most purposes though some raised concerns and would expect an opportunity and require detail to determine if they are willing to share for specific purposes such as research. There is a preference for data usage and privacy policies to be in easy language with links to more detailed information. Members suggested having someone in a trusted position, such as a practice manager, that they could seek clarification of these policies. Information regarding data can be overwhelming and easily misunderstood. They also discussed concerns with privacy and cyber breaches.

Data Sharing and Linkage -
Is this something on the radar for health consumers?

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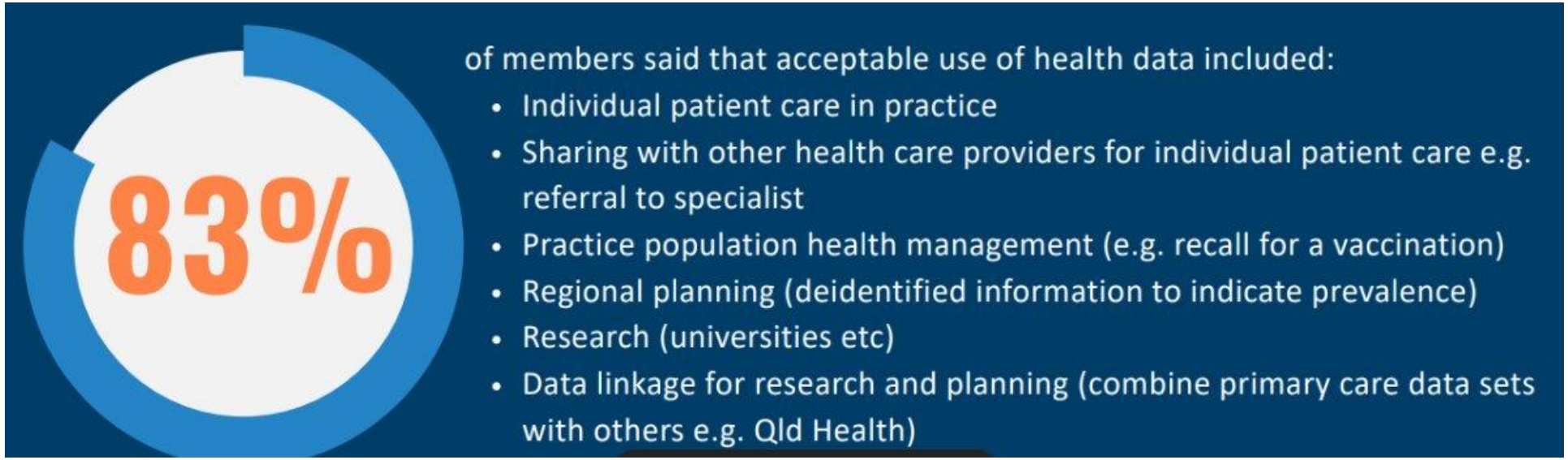
GCPHN CAC Feedback



- **Is anything missing?**

- **What additional information, resources would you expect as a general practice to help your practice and your patients understand how health data is being used including data linkage?**

PHASES

SMARTER TOOLS FOR STRONGER HEARTS

***P**reventing **H**eart **A**ttacks and **S**troke **E**vents through **S**urveillance*
5-Year Project

Statewide collaboration of Queensland PHNs
Funded by Queensland Health and Department of Health and Aged Care

phn QUEENSLAND PHNs
An Australian Government Initiative

Commonwealth Wound Consumables Scheme (CWCS)

Katie Garrett
Program Manager (Commissioning)

Gold Coast Primary Health Network

Commonwealth Wound Consumables Scheme (CWCS)

Supporting Nurses in Delivering Better Wound Care

Commonwealth Wound Consumables Scheme (CWCS)

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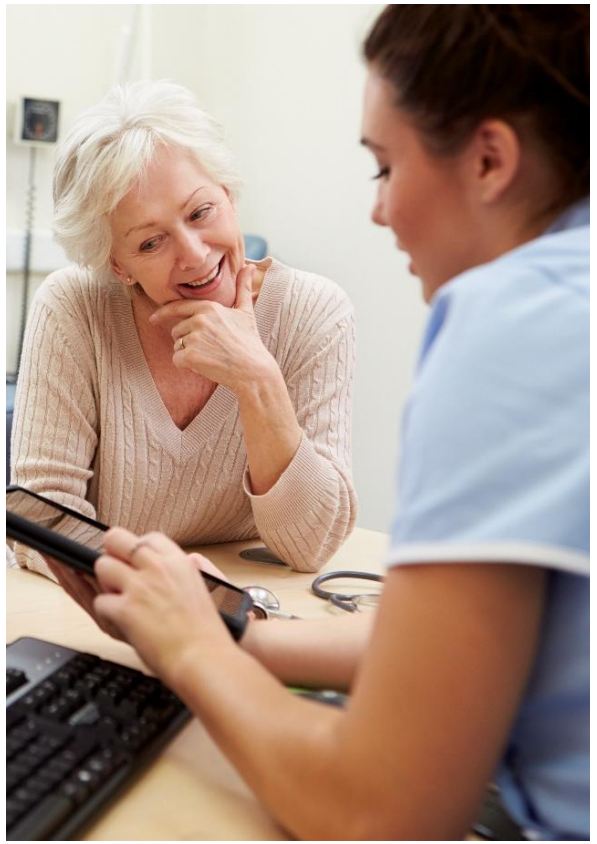
Who is eligible?

People with diabetes with a chronic wound who are:

- Aged 65+ (or 50+ for a First Nations Person)
- Patient has a chronic wound (>6 weeks duration)
- Holds a valid Commonwealth concession card (pensioner, health care, seniors)
- Lives in the community (not in RACH or hospital)



Commonwealth Wound Consumables Scheme (CWCS)

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An Australian Government Initiative

Covered consumables include:

- Adhesive and non-adhesive dressings
- Hydrogels, hydrocolloids, alginates
- Compression bandages
- Barrier creams and tapes

Not covered:

- Clinical services or consultations
- Wound cleansers or antiseptic solutions
- Surgical supplies (scalpels, forceps)
- Items used for acute wounds (e.g. post-op)

Commonwealth Wound Consumables Scheme (CWCS)

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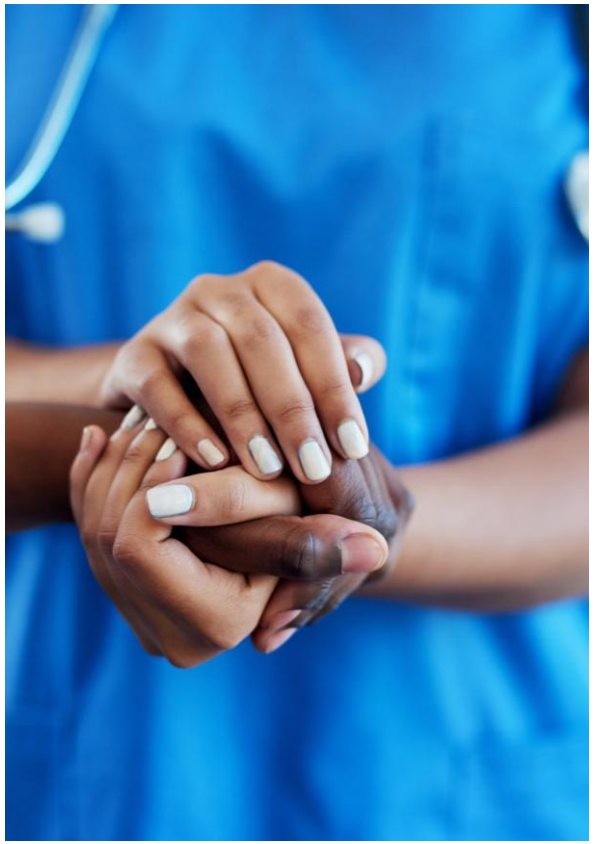
An Australian Government Initiative

Eligible health professionals

- Aboriginal and Torres Strait Islander health practitioners
- medical practitioners in a primary care setting, including general practitioners
- registered nurses and nurse practitioners
- podiatrists.

**Eligible health professionals will need to complete specified training to use the online portal*



Commonwealth Wound Consumables Scheme (CWCS)

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Nurses must be registered in HPOS (Health Professional Online Services) to register eligible patients.

- MyGovID required
- Link to PRODA account
- Navigate to CWCS tile in HPOS to complete registration
- Must be a nurse practitioner or registered nurse working in a participating general practice

Osteoporosis – The Silent Disease

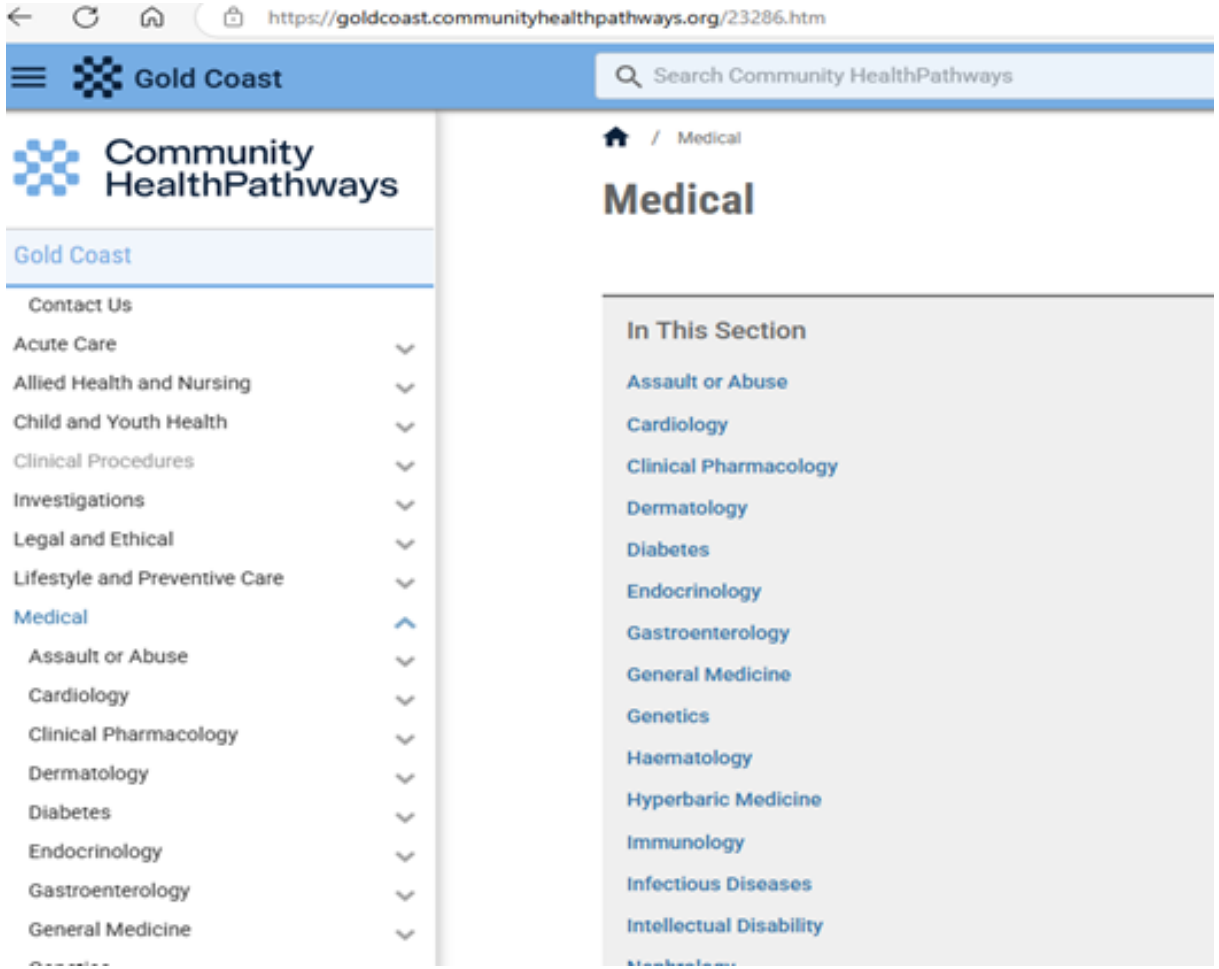
Tim Lyons
Nurse Practitioner - Endocrinology

Gold Coast University Hospital

Osteoporosis

The Silent Disease

By Tim Lyons



https://goldcoast.communityhealthpathways.org/24517.htm

Definition of Osteoporosis

- “porous bone” – decrease in bone density and mass
- Bone mineral density T-Score ≤ -2.5 or presence of a minimal trauma fracture
- Asymptomatic before fracture (silent disease)
- Women 4x more affected than men
- Post hip fracture:
  - 25% 1-year mortality
  - 40% need mobility aids

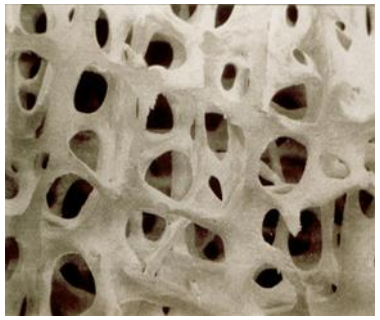
Bone Tissue

There are two basic types of bone tissue:

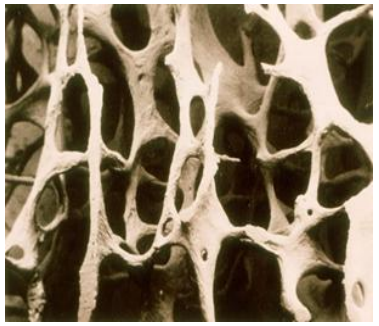
- **cortical bone** (compact or dense bone)
- **trabecular bone** (cancellous bone)

Bone Turnover

- Trabecular bone turns over every 3 to 4 years
- Cortical bone is replaced every 10 years, approx.



Normal bone

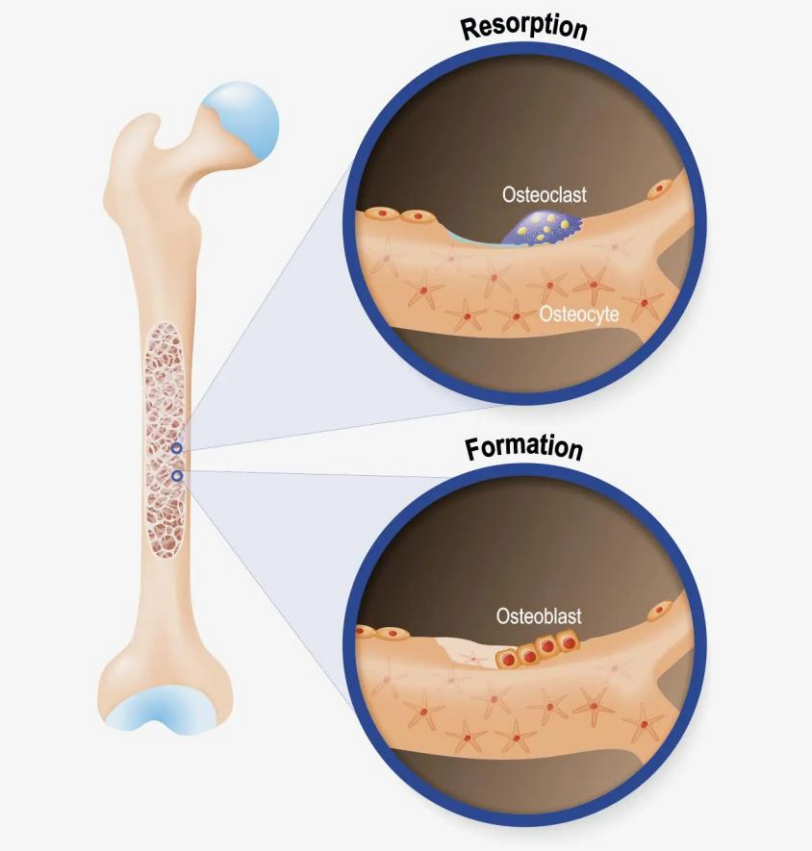


Osteoporosis

Bone Remodelling

Osteoclasts: break down and resorb bone (Resorption)

Osteoblasts: make new bone (Formation)



Minimal Trauma Fracture

- Low energy trauma - unexpected from mechanism of injury
- Common sites: wrist, humerus, femur, pelvis, hip, spine
- Vertebral compression fracture: ≥20% height loss
- Hallmark of osteoporosis

Clinical Osteoporosis

- Those >50 years of age PLUS a MTF of the vertebra or hip – **clinical osteoporosis**
- Those >50 years of age PLUS other MFTs and a BMD T-score below -1.5 – **clinical osteoporosis**

Assessment

Risk Factors

Aged ≥ 70 years without any other risk factors

Aged > 60 years for men

Aged > 50 years for women **PLUS** any of:

- Prior fracture
- Falls
- Early menopause (<40 years)
- Parental history
- Smoking
- ETOH
- Calcium-deficient

Red Flags

- **Glucocorticoid use ≥ 3 months**
- **Heavy alcohol use**
- **Previous MTF**

Assessment

Ask about…

Medical conditions:

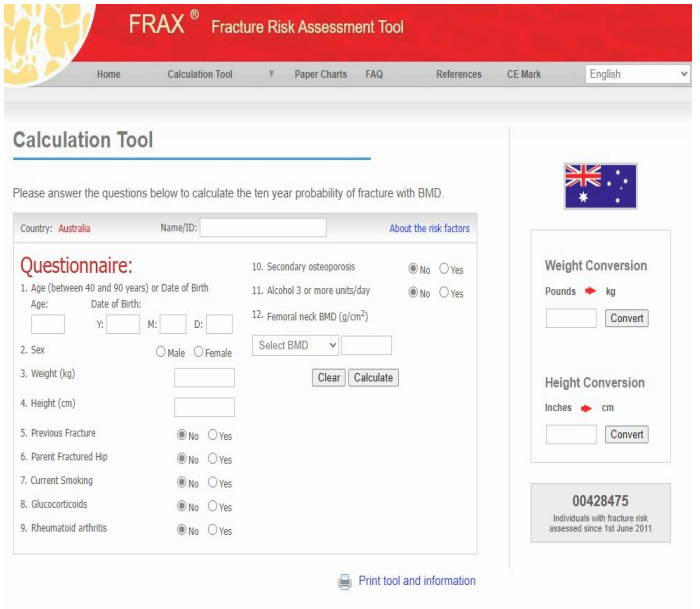
- Diabetes
- Epilepsy
- RA
- Malabsorption (Coeliac, IBD, bariatric surgery)
- Vitamin D deficiency
- Self-limiting acute back pain (possible vertebral #)

Medications:

- Glucocorticoids (prednisolone ≥7.5mg/day, ≥ 3mths)
- Antiepileptic drugs
- Chemotherapy

Assessment

- Absolute fracture risk - Fracture Risk Assessment Tool
- >50 years with lifestyle/ non-modifiable risk factors
- Those who do not clearly fit established criteria
- Consider DEXA if Major Osteoporotic Fracture (MOF) risk ≥ 10% (not recommended if <10%
- Treat if >50 yrs and MOF risk is ≥20%, or if risk of hip fracture is ≥3%,
- Re-stratify with DEXA results + other criteria for treatment options



FRAX – Australian cohort
Developed by the University of Sheffield, UK
www.shef.ac.uk/FRAX/tool.aspx?country=31

Investigations

- Thoracolumbar X-ray: if ≥3 cm height loss or back pain
- DEXA scan:
  - postmenopausal women >50 with MTF
  - >70 years
  - Vertebral fracture
  - Risk of osteoporosis
- Baseline pathology:
  - FBC, LFT, Vit-D, Calcium
  - 2nd causes coeliac tests, TSH, FSH, PTH

Bone Mineral Density (BMD)

DEXA scan

(Dual-energy X-ray Absorptiometry)

T-Score: Normal ≥ -1.0

Osteopenia -1.0 to -2.5

Osteoporosis ≤ -2.5

Z-Score:

for <50 years

low < -2.0

Predicts 10-year fracture risk

Refer to same radiologist for continuity

Repeat every 2 years based on risk

HEALTHY BONES AUSTRALIA

Bone density testing in general practice

A guide to Dual Energy X-ray Absorptiometry (DXA)

Scanning of the axial skeleton by dual energy X-ray absorptiometry (DXA) is the gold standard in Australia for the measurement of bone mineral density (BMD). DXA is a diagnostic tool for osteoporosis or osteopenia, enabling doctors to determine the extent of bone loss for clinical decision making. This guide outlines who to refer for DXA and the basics of how to interpret a bone densitometry report. Note the terminology of osteopenia and osteoporosis based on BMD alone in intended for individuals over 50 years of age and menopausal women.

Poor bone health is common in Australia

An estimated 4.7 million Australians over the age of 50 years have osteoporosis or osteopenia, with over 183,000 associated fractures (2022). Early diagnosis and improved management can reduce the current annual cost of $3.84 billion, with fracture costs accounting for up to 67% of overall costs.

In general practice, early detection can prevent a first fracture. For patients who have already fractured, investigation and initiation of osteoporosis medication is crucial to reduce the very high risk of subsequent fractures.

Who to send for a DXA scan

Patients over 50 with risk factors	MBS item
Family history – parent with hip fracture	No rebate
Early menopause	12312
Hypogonadism	12312
Anticipated glucocorticoids ≥ 4 months ≥ 7.5mg/day	12312
Coeliac disease/malabsorption disorders	12315
Rheumatoid arthritis	12315
Primary hyperparathyroidism	12315
Hyperthyroidism	12315
Chronic kidney or liver disease	12315
Androgen deprivation therapy	12312
Recurrent falls	No rebate
Breast cancer on aromatase inhibitors	No rebate
Treatment with antiepileptic medications	No rebate
Low body weight	No rebate
HIV and its treatment	No rebate
Major depression/ SSRI treatment	No rebate
Type 1 and type 2 diabetes mellitus	No rebate
Multiple myeloma/monoclonal gammopathy	No rebate
Organ or bone marrow transplant (item 12312 applies if treated with glucocorticoids or if kidney disease present)	No rebate

Patients with a minimal trauma fracture	MBS item
DXA is recommended to establish a baseline BMD for treatment	12306

Suspected vertebral fracture	MBS item
Refer for spinal X-ray when: – Height loss of 3cm or more – Thoracic kyphosis – New onset back pain suggestive of fracture	
If fracture confirmed, therapy indicated, refer for DXA	12306
Vertebral fracture assessment (VFA), also known as Lateral vertebral assessment (LVA) is offered with some DXA scans. VFA may be a useful screen for fractures in people with height loss. MBS rebate not available for VFA.	

Patients with osteoporosis	MBS item
T-score equal to or less than -2.5 eligible for one scan every two years	12306

Patients over 70 years of age	MBS item
For men and women over 70 years, MBS rebate applies (regardless of other risk factors)	12320
Patients with a normal result or mild osteopenia (measured by a T-score down to -1.5) eligible for one scan every 5 years	12320
Patients with moderate to marked osteopenia (as measured by a T-score less than -1.5 and above -2.5) will be eligible for one scan every two years	12322

The DXA report

The level of detail provided in a DXA report varies. To comply with guidelines, all reports should state the make and model of the DXA machine used, BMD (measured in g/cm²), T-score and Z-score. Many DXA reports also provide an Absolute Fracture Risk result.

T-score results
- **-2.5 or lower** is osteoporosis and
- T-score **between -1 and -2.5** is osteopenia

in over 50s and menopausal women.
Refer to RACGP Guidelines recommendation when individual has minimal trauma fracture*

Z-score
- Useful indicator of increased bone loss
- Particular importance in under 50s
- At any age Z-score **-2.0 or lower** is 'below expected range for age' and should trigger investigation to exclude underlying disease cause bone loss

Medical Imaging Centre – Bone Densitometry Report

Dear Doctor

Re: [Patient] **DOB: .....**

This patient attended on ..... for bone densitometry of AP spine and left hip.

Bone mineral density was measured by [DXA machine make and model]. The results are summarised below:

Scan date: ..... **Sex: Female**

Age at scan: ..... years **Ethnicity: .....**

L1–L4 or L2-L4 usually measured.

Total proximal femur and femoral neck reported. Bilateral hip scans preferable.

Scan site	Region	BMD	T-score	Z-score	Change vs Baseline (%)	Change vs last (%)
AP spine	L2-L4	0.890	-2.6	-1.1	##%	##%
Left femur	Total	0.822	-1.5	-0.4	##%	##%
	Neck	0.831	-1.5	-0.0	##%	##%

This percentage indicates the change in BMD compared to the first scan performed.

FRAX – Absolute fracture risk assessment tool. Most DXA centres can provide this as part of DXA report. RACGP guidelines recommend treating patients over 50 years with a 10-year result of
- 20% or greater risk of major osteoporotic fracture (MOF)

or,
- 3% or greater risk of hip fracture

Absolute Fracture Risk (AFR):

Major Osteoporotic Fracture: 20% **Hip Fracture:** 3.5%

Risk Factors: None

Trabecular Bone Score (TBS): L1-L4 is #.##

TBS – Trabecular Bone Score. Offered by some centers, to assess bone micro-architecture. TBS result can be used to adjust FRAX result. TBS does not attract an MBS rebate.

Vertebral fracture assessment: VFA demonstrates a deformity of L3, indicating a probable vertebral fracture. Confirmation with X-ray is recommended.

VFA (vertebral fracture assessment – also known as Lateral vertebral assessment LVA) is offered by some imaging centres. It is a useful screening tool for asymptomatic vertebral fracture. Fractures detected by VFA should be confirmed by plain x-ray. VFA does not attract an MBS rebate.

T-score

Osteopenia	**T-score between -1.0 and -2.5**	BMD between 1.0 and 2.5 SDs below young adult mean
Osteoporosis	**T-score -2.5 or below**	BMD 2.5 or more SDs below young adult mean

The T-score compares the patient's bone density to the peak bone density of young adults. It is the number of standard deviations (SDs) of the BMD measurement above or below the mean BMD of young healthy adults of the same sex. According to the World Health Organisation, osteopenia and osteoporosis can be diagnosed in individuals over 50, and in menopausal women, based on the T-scores.

***NOTE: As outlined in RACGP Guidelines**

Individuals over 50 years with a **low trauma hip or vertebral fracture** are considered to have clinical osteoporosis.

Individuals over 50 years with **other low trauma fractures, and a T-score below –1.5**, (BMD in the lower osteopenic or osteoporotic range), are also considered to have clinical osteoporosis.

Z-score

The Z-score is the number of SDs of the BMD above or below the mean BMD of adults of the same age and sex.

Z-score is a useful indicator of increased bone loss and is of particular importance below 50 years. At any age, a **Z-score -2.0 or lower** is 'below the expected range for age' and should trigger investigation to exclude underlying disease causing bone loss. A **Z-score above -2.0** is 'within the expected range for age'.

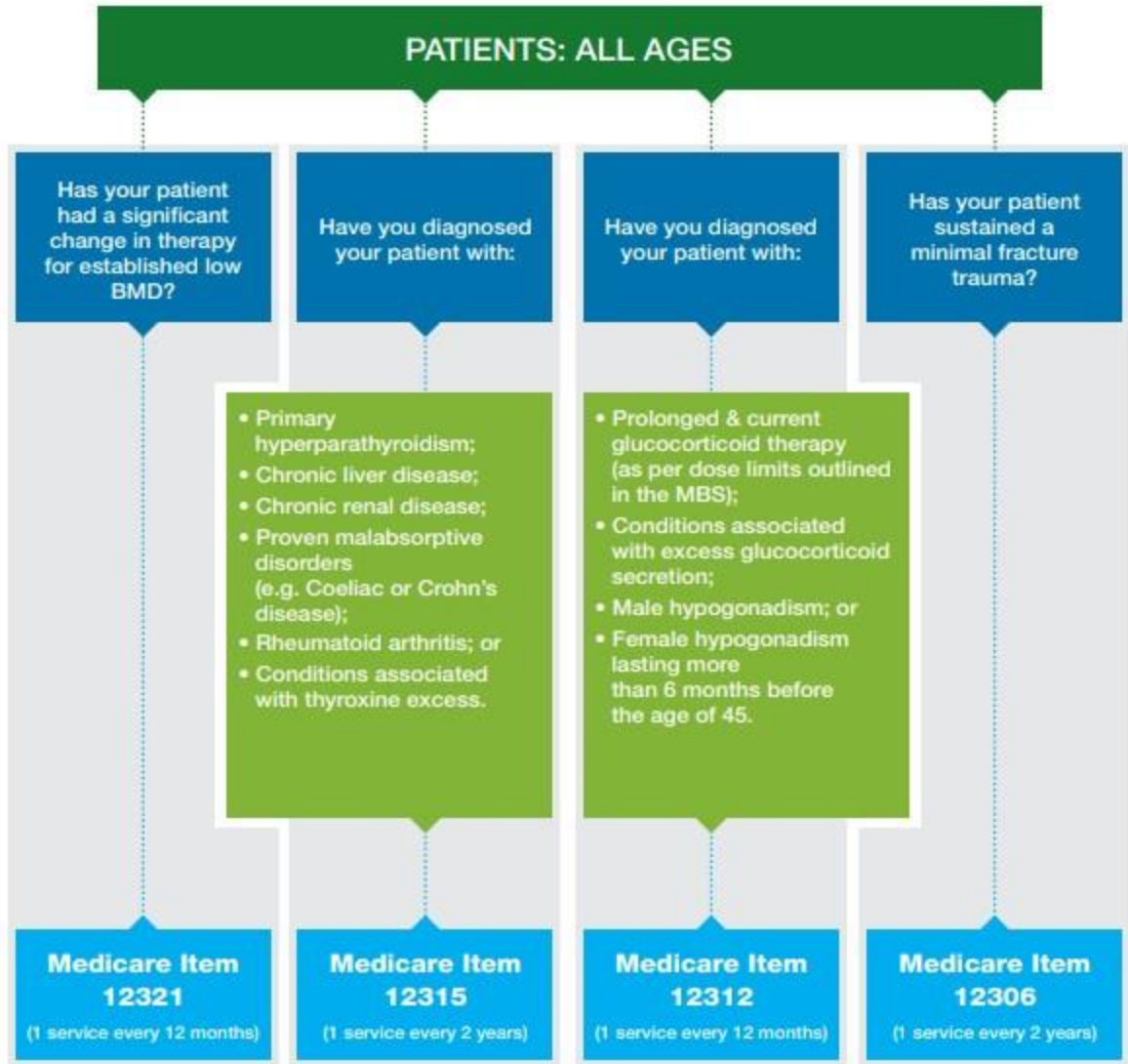
www.healthybonesaustralia.org.au

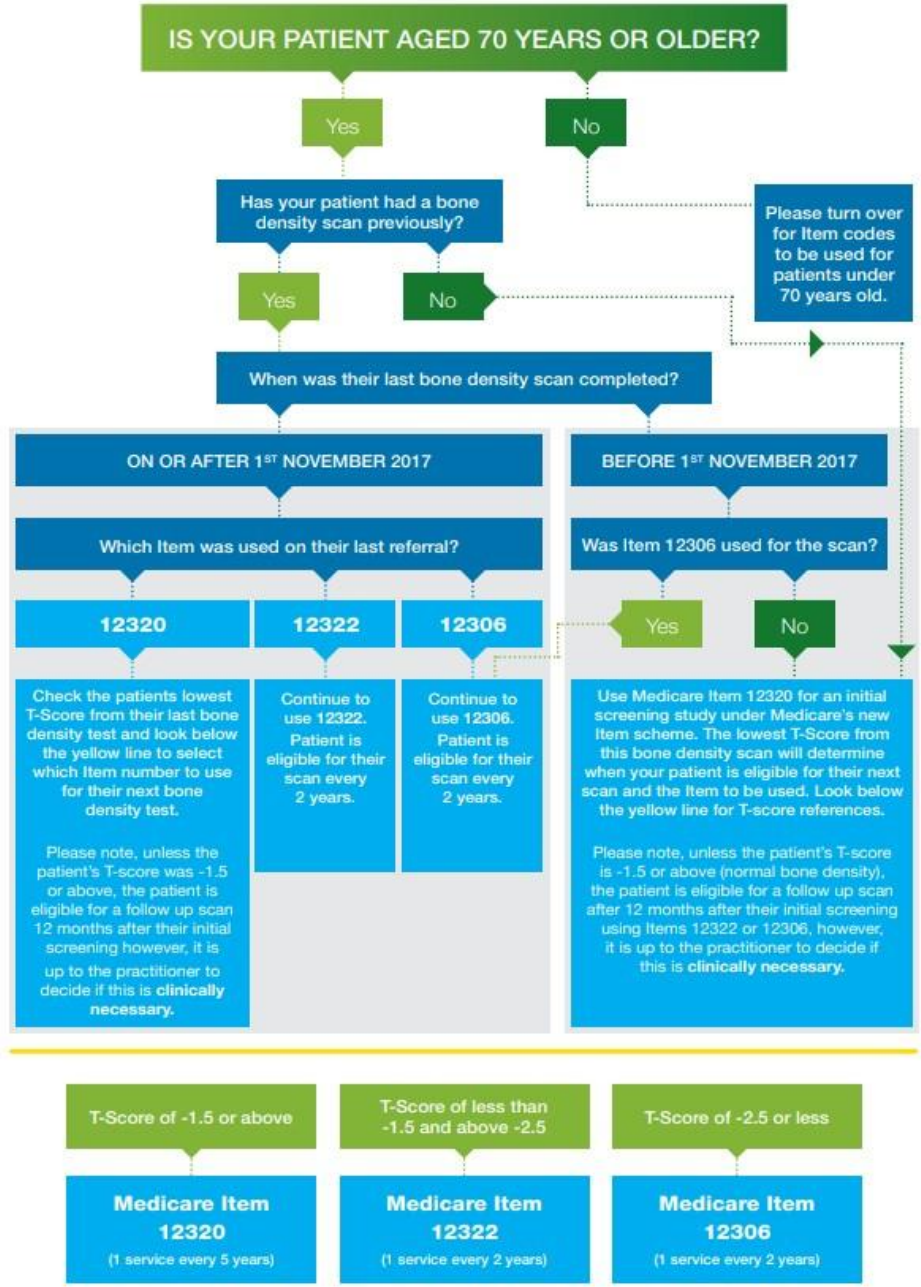
National toll-free number for patients 1800 242 141

HEALTHY BONES AUSTRALIA Protect Build Support

https://healthybonesaustralia.org.au/wp-content/uploads/2024/03/hba-gp-bone-density-brochure-2022-v9.pdf

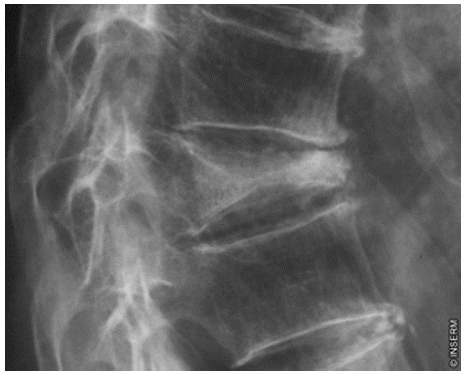
Do you know the Bone Densitometry Medicare Item Codes?



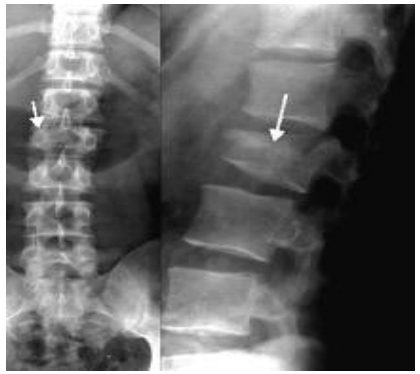

IS YOUR PATIENT AGED 70 YEARS OR OLDER?
Yes
No
Has your patient had a bone density scan previously?
Please turn over for Item codes to be used for patients under 70 years old.
Yes
No
When was their last bone density scan completed?
ON OR AFTER 1ST NOVEMBER 2017
BEFORE 1ST NOVEMBER 2017
Which Item was used on their last referral?
Was Item 12306 used for the scan?
12320
12322
12306
Yes
No
Check the patients lowest T-Score from their last bone density test and look below the yellow line to select which Item number to use for their next bone density test.
Please note, unless the patient's T-score was -1.5 or above, the patient is eligible for a follow up scan 12 months after their initial screening however, it is up to the practitioner to decide if this is clinically necessary.
Continue to use 12322. Patient is eligible for their scan every 2 years.
Continue to use 12306. Patient is eligible for their scan every 2 years.
Use Medicare Item 12320 for an initial screening study under Medicare's new Item scheme. The lowest T-Score from this bone density scan will determine when your patient is eligible for their next scan and the Item to be used. Look below the yellow line for T-score references.
Please note, unless the patient's T-score is -1.5 or above (normal bone density), the patient is eligible for a follow up scan after 12 months after their initial screening using Items 12322 or 12306, however, it is up to the practitioner to decide if this is clinically necessary.
T-Score of -1.5 or above
T-Score of less than -1.5 and above -2.5
T-Score of -2.5 or less
Medicare Item 12320
(1 service every 5 years)
Medicare Item 12322
(1 service every 2 years)
Medicare Item 12306
(1 service every 2 years)

Management

- Review BMD/XR results
  - What is the T/Z-Score?
  - Vertebral fracture?
    - Most common
    - Most are silent
- Lifestyle interventions
  - Optimised?
- Pharmacological treatment
  - Dental assessment
- Endocrinology referral for complex cases
  - Complex cases
  - Qualify for specialist treatment



Thoracic vertebra



Lumbar vertebra

Lifestyle Interventions

- Weight-bearing impact exercises 2–3x/week
- High-intensity resistance training (ONERO program)
- Avoid smoking and excess alcohol (>2 drinks/day)
- Vitamin D via sunlight, supplements if needed
- Calcium optimization and patient education (Healthy Bones Australia)

Vitamin D

- Sun exposure is dependent on skin type and cancer risk
- Gold Coast winter: 5-10 mins daily, 4 days a week, 35% of skin exposed vs 6-20 mins (deeply pigmented skin)
- Not greatly affected by sunscreen
- Mild deficiency: 1000-2000IU orally daily
- Moderate deficiency: 3000-5000IU daily for 6-8 weeks then 1000-2000 daily
- Consider IM Vitamin D, malabsorption issues

Calcium

- Calcium absorption is reliant on vitamin D
- 1000-1300mg daily (Adults/adolescents)
- 1300mg/day for:
  - Men aged >70 years
  - Women aged >50
  - Adolescents aged 12-18 years
  - Medicated for osteoporosis
- Sourced from diet (600mg)
- Calcium/vitamin D combination

Pharmacological Treatment

- Anti-osteoporosis therapy can reduce future fracture risk
  - 40-70% for vertebral fractures
  - ~25% for non-vertebral fracture

- Dental check before treatment

- Medication-related osteoporosis of the jaw
  - Bisphosphonates and denosumab
  - 1-100 per 100,000 patients
  - Benefits outweigh small risks

Pharmacological Treatment

- Denosumab (Prolia)
  - Inhibits bone resorption (Osteoclasts)
  - 6-monthly SC
  - Aim ≤10-year course
  - Consolidate with bisphosphonate after stopping

  Give 12-month course of an oral bisphosphonate or 1x IV dose of Aclasta 6 months after the last denosumab dose to prevent rebound rapid bone loss.

  When switching to bisphosphonate after a MISSED denosumab dose, aim to start within 4 weeks or ASAP from when missed dose was due.

- Bisphosphonates
  - Oral (Fosamax, Actonel)
  - IV (Aclasta)
    - If intolerant to oral
    - More convenient

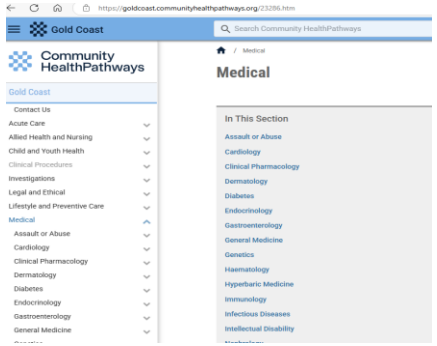
Specialist Referrals

Romosozumab: T ≤ -2.5 + vertebral/hip # or 2 MTF (first line)

- Romosozumab: T ≤ -3.0 + 2 MTF after antiresorptives (second line)

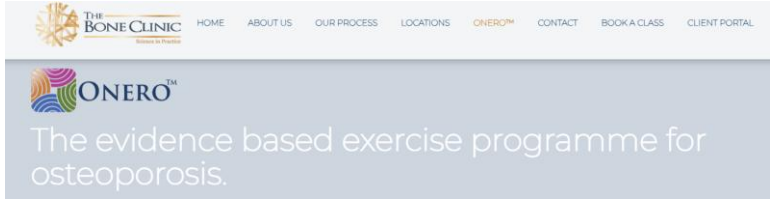
- Teriparatide: T ≤ -3.0 + 2 MTF post-treatment

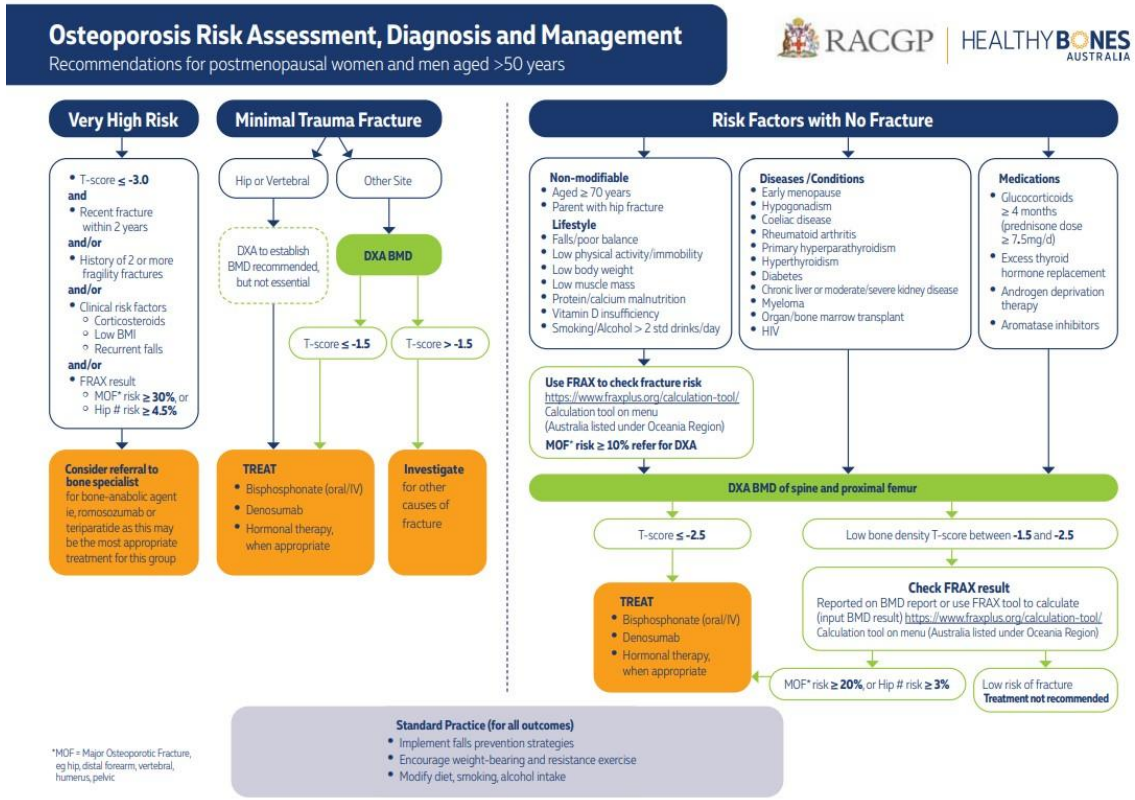
Community HealthPathways

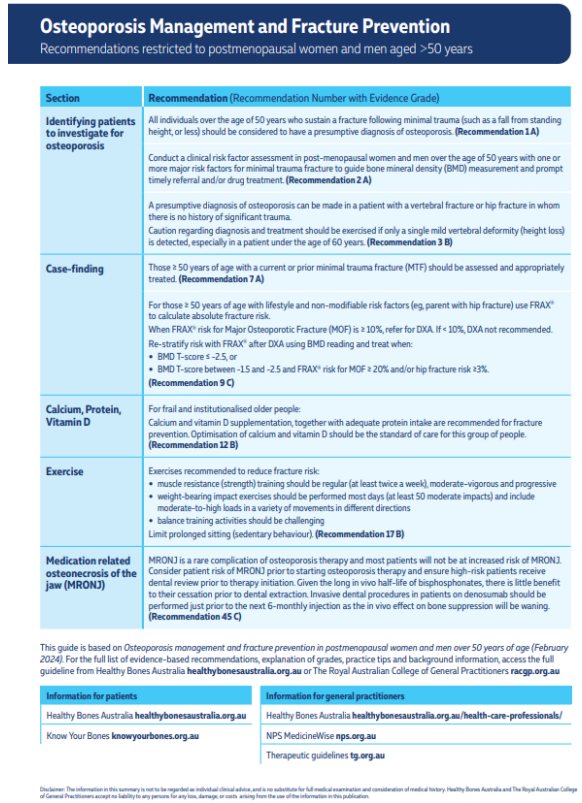


Healthy Bones Australia

The Bone Clinic – ONERO Program







Osteoporosis Management and Fracture Prevention

Recommendations restricted to postmenopausal women and men aged >50 years

Section	**Recommendation** (Recommendation Number with Evidence Grade)
Identifying patients to investigate for osteoporosis	All individuals over the age of 50 years who sustain a fracture following minimal trauma (such as a fall from standing height, or less) should be considered to have a presumptive diagnosis of osteoporosis. **(Recommendation 1 A)** Conduct a clinical risk factor assessment in post-menopausal women and men over the age of 50 years with one or more major risk factors for minimal trauma fracture to guide bone mineral density (BMD) measurement and prompt timely referral and/or drug treatment. **(Recommendation 2 A)** A presumptive diagnosis of osteoporosis can be made in a patient with a vertebral fracture or hip fracture in whom there is no history of significant trauma. Caution regarding diagnosis and treatment should be exercised if only a single mild vertebral deformity (height loss) is detected, especially in a patient under the age of 60 years. **(Recommendation 3 B)**
Case-finding	Those ≥ 50 years of age with a current or prior minimal trauma fracture (MTF) should be assessed and appropriately treated. **(Recommendation 7 A)** For those ≥ 50 years of age with lifestyle and non-modifiable risk factors (eg, parent with hip fracture) use FRAX® to calculate absolute fracture risk. When FRAX® risk for Major Osteoporotic Fracture (MOF) is ≥ 10%, refer for DXA. If < 10%, DXA not recommended. Re-stratify risk with FRAX® after DXA using BMD reading and treat when: • BMD T-score ≤ -2.5, or • BMD T-score between -1.5 and -2.5 and FRAX® risk for MOF ≥ 20% and/or hip fracture risk ≥3%. **(Recommendation 9 C)**
Calcium, Protein, Vitamin D	For frail and institutionalised older people: Calcium and vitamin D supplementation, together with adequate protein intake are recommended for fracture prevention. Optimisation of calcium and vitamin D should be the standard of care for this group of people. **(Recommendation 12 B)**
Exercise	Exercises recommended to reduce fracture risk: • muscle resistance (strength) training should be regular (at least twice a week), moderate–vigorous and progressive • weight-bearing impact exercises should be performed most days (at least 50 moderate impacts) and include moderate-to-high loads in a variety of movements in different directions • balance training activities should be challenging Limit prolonged sitting (sedentary behaviour). **(Recommendation 17 B)**
Medication related osteonecrosis of the jaw (MRONJ)	MRONJ is a rare complication of osteoporosis therapy and most patients will not be at increased risk of MRONJ. Consider patient risk of MRONJ prior to starting osteoporosis therapy and ensure high-risk patients receive dental review prior to therapy initiation. Given the long in vivo half-life of bisphosphonates, there is little benefit to their cessation prior to dental extraction. Invasive dental procedures in patients on denosumab should be performed just prior to the next 6-monthly injection as the in vivo effect on bone suppression will be waning. **(Recommendation 45 C)**

This guide is based on *Osteoporosis management and fracture prevention in postmenopausal women and men over 50 years of age (February 2024)*. For the full list of evidence-based recommendations, explanation of grades, practice tips and background information, access the full guideline from Healthy Bones Australia **healthybonesaustralia.org.au** or The Royal Australian College of General Practitioners **racgp.org.au**

Information for patients	Information for general practitioners
Healthy Bones Australia **healthybonesaustralia.org.au**	Healthy Bones Australia **healthybonesaustralia.org.au/health-care-professionals/**
Know Your Bones **knowyourbones.org.au**	NPS MedicineWise **nps.org.au**
	Therapeutic guidelines **tg.org.au**

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Hip fracture care pathways in Australia. Australian Institute of Health and Welfare; 2023 Nov 24.

Journal of Oral and Maxillofacial Surgery, 2010-02-01, Volume 68, Issue 2, Pages 243-253, Copyright © 2010 American Association of Oral and Maxillofacial Surgeons

Osteoporosis and minimal trauma fractures. Australian Institute of Health and Welfare; 2024 Jun 17.

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Ruggiero SL, Dodson TB, Aghaloo T, et al. American Association of Oral and Maxillofacial Surgeons' Position Paper on Medication-Related Osteonecrosis of the Jaws-2022 Update. J Oral Maxillofac Surg. 2022 May; 80(5):920-943.

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Chronic Condition Management Framework

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New Chronic Condition Management Framework

From 1 July 2025, GPMPs and TCAs will be replaced with a single GP chronic condition management plan (GPCCMP).

- Overview of changes commencing July 1, 2025
- Care planning workflow
- Team roles and responsibilities
- Tips to get prepared
- Discussion points

New Chronic Condition Management Framework

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Aspect	Current (pre-1 July 2025)	Future (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

Source: Preparing for Changes to Chronic Condition Management Brisbane South PHN & Prestantia Health

Care Planning Workflow

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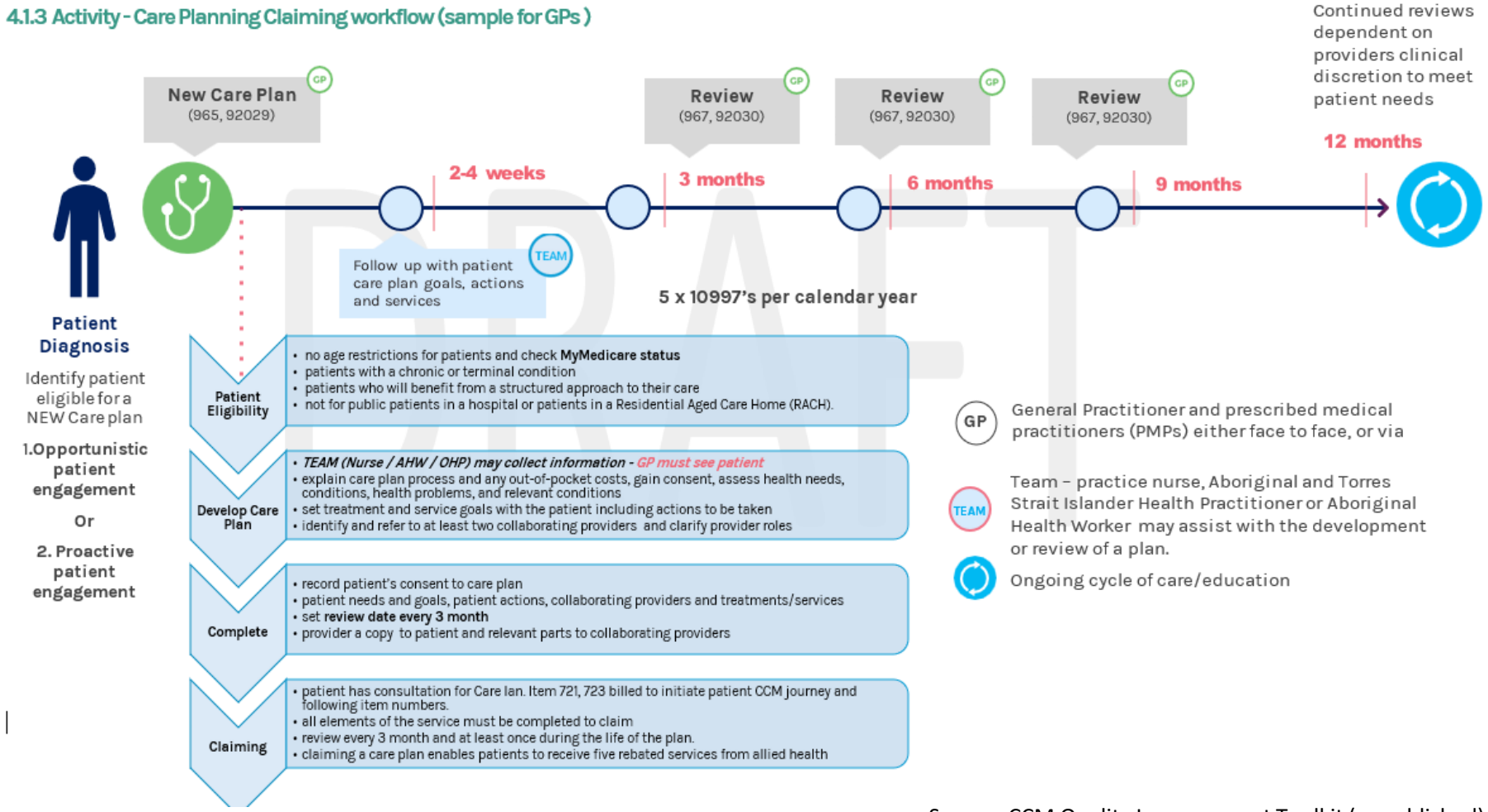

Source: CCM Quality Improvement Toolkit (unpublished)

Team Roles & Responsibilities

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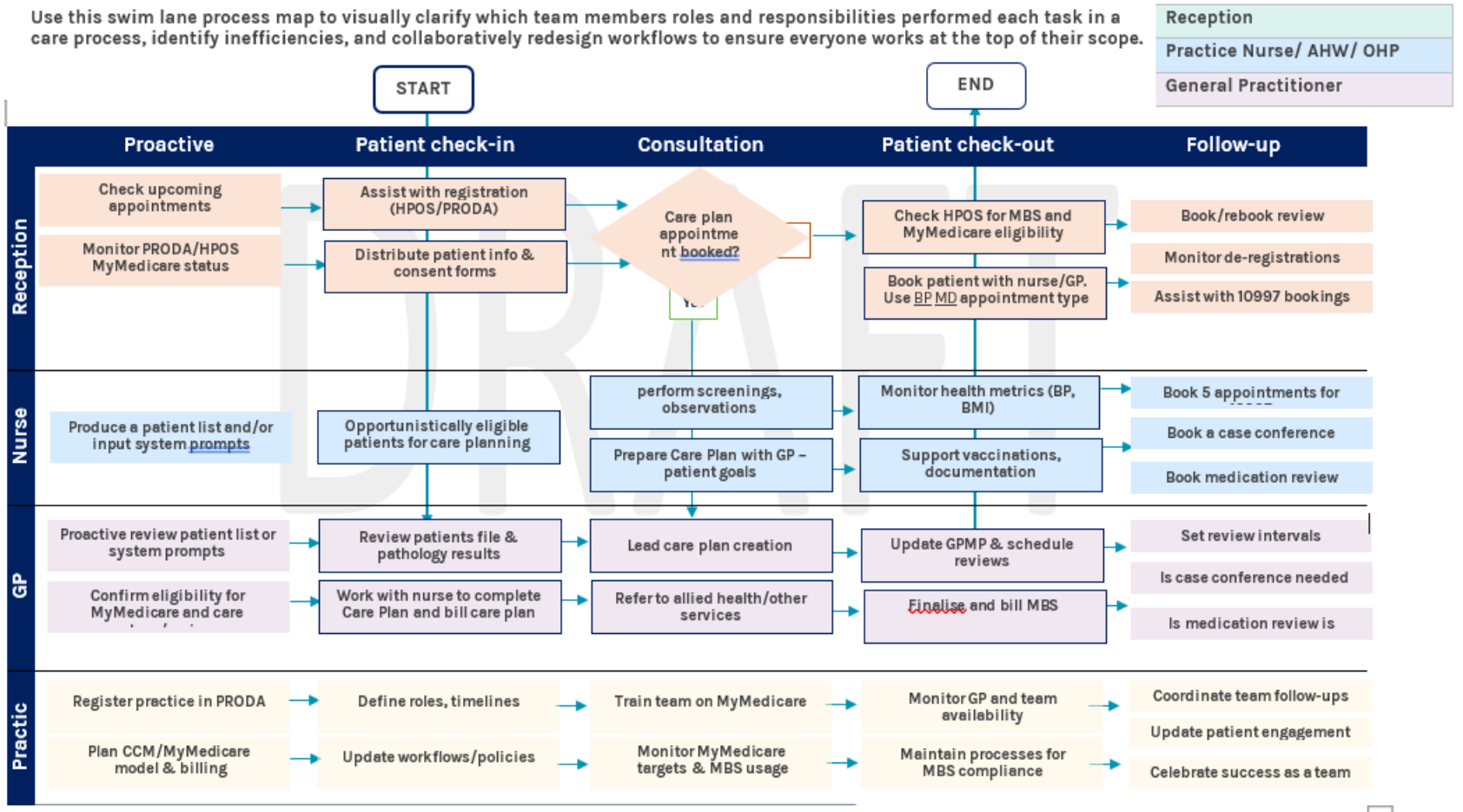
4.1.4 Activity – Swim Lane - Roles and Responsibility

Use this swim lane process map to visually clarify which team members roles and responsibilities performed each task in a care process, identify inefficiencies, and collaboratively redesign workflows to ensure everyone works at the top of their scope.



Source: CCM Quality Improvement Toolkit (unpublished)

Preparing a GPCCMP will be defined as preparing a written plan which describes:

- The patient's chronic condition(s) and associated health care needs
- Health and lifestyle goals developed by the patient and medical practitioner using a shared decision-making approach;
- Actions to be taken by the patient
- Treatment and services the patient is likely to need if the patient would benefit from multidisciplinary care to manage the chronic condition(s) the services that the medical practitioner will refer the patient to (including the purposes of those treatments or services)
- arrangements to review the plan, including the proposed timeframe for review (3 months allowed)
- Need patient consent
- Need to offer to the patient
- "Encouraged" to upload to the MHR

Tips to get prepared

- Patients on existing GPMP and TCA booked in for reviews from July 1 **will need to be transitioned** to a GPCCMP

    - Check MyMedicare the patient is registered for MyMedicare
        - *Consider the patient journey and where MyMedicare is introduced, patients are registered, and patient registrations are validated*
    - Prepare a GPCCMP Plan
    - Book review appointment (at the time of the appointment)

- Updating CDM resources, templates
- Data cleansing
- Use Primary Sense
    - Identify patients with current care plans booked in for a review/due for a review
        - Patients with High Complexity (level 5 & 4)
    - Patients with Moderate Complexity (level 3)
        - Identify patients with 1 chronic condition (eligible for GPCCMP)

Resources

- MBS framework for managing patients with chronic conditions in primary care. MBS Online - Upcoming changes to the MBS Chronic Disease Management Framework

- MBS Transition Arrangements for Existing Patients PDF Version - Upcoming Changes to Chronic Disease Management MBS Items – Transition Arrangements for Existing Patients.PDF

- MBS 965 Item Description

- MBS 967 Item Description

Upcoming Chronic Condition Management Events:

CDM Plus Webinars on the 29th of July at 12:30pm and 14th of August at 6pm
CDM Plus Chronic Conditions Management 2-Day Workshop on 15th –16th July

Resources

- Validate MyMedicare Registrations
    - How to Download a MyMedicare Patient Registration List in PRODA
    - How to Upload a MyMedicare Patient Registration List in Medical Director
    - How to Import a MyMedicare Patient Registration List CSV in Best Practice
- Ensure all patients attending the General Practice for a GPMP review or TCA review appointment are transitioned to a new GPCCMP (View the MBS Item Description for details about what to include in a GPCCMP)
- Order MyMedicare brochures

Next meeting

Wednesday 13 August 2025

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GOLD COAST

An Australian Government Initiative

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