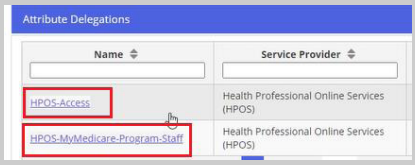
1.1 Pre-Activity – Practice Readiness Checklist

Before commencing your activity, evaluate your **practice's readiness to implement MyMedicare and CCM.** Engage your leadership team to confirm registration status and ensure a smooth transition.

Step 1	Actions	Assigned to
Plan the transition	☐ Nominate a **CCM change lead** and team	
	☐ Document the **change** plan, timeline, patient registers, and team responsibilities *Need help? Contact your* **Gold Coast PHC Engagement Officer**	
	☐ Meet with the team, define team roles, responsibilities, and timelines	
	☐ Conduct **data cleansing and archive** inactive records	
	☐ Set up a shared folder for documentation (e.g. Teams/Google Drive)	
	☐ Coordinate audits and maintain up-to-date patient registers (**Use GCPHN Data Cleansing Toolkit**)	
	☐ Schedule regular team meetings to track progress	

Step 2	Actions	Assigned to
System & Resource Setup	☐ Register practice and providers in **PRODA**	
	☐ Assign team in **PRODA organisation account delegations and permissions** 	
	☐ Add MyMedicare to 'My Programs' in **HPOS**	
	☐ Update **workflows,** templates, and policies (if needed)	
	☐ Allocate team time for updates and training	
	☐ Audit existing CDM resources and store centrally for ease of access	

Step 3	Actions	Assigned to
Prepare your team	☐ Train the team in MyMedicare **benefits, registration** and **CCM changes**	
	☐ Define roles and workflows (use the **Swim Lane template**)	
	☐ Allocate protected time for each team member's transition role	
	☐ Provide regular updates to the team via internal communication	
	☐ Refer clinicians to **HealthPathways** for the latest guidelines and referral pathways	
	☐ Brief Allied Health providers on upcoming changes (refer to **Referral Arrangements for Allied Health Services**)	

Step 4	Actions	Assigned to
Patient Engagement & Registration	☐ Use MyMedicare Communication kit (brochures, posters, videos, website & social media)	
	☐ Ensure reception staff register patients opportunistically and **invite others** (SMS, email, or in-person)	
	☐ Communicate the shift from CDM to CCM to patients	
	☐ Assist patients with **form completion** or digital registration	
	☐ Confirm who will add/invite patients to MyMedicare via PRODA. Make sure to enable **'Auto Accept'** for registrations in MyMedicare Preferences via PRODA.	
	☐ Regularly import registered patient lists into your CMS refer to guides **Best Practice** **Medical Director** **Cubiko**	
	☐ Monitor de-registrations via HPOS – refer activity **Management registration via HPOS**	

Step 5	Actions	Assigned to
Patient Identification & Recall	☐ Use Primary Sense Patients with High Complexity 5 & 4 Report to identify eligible patients.	
	☐ Offer GPCCMP plans opportunistically (during consults, HA's, immunisations)	
	☐ Recall existing CDM patients to update them to GPCCMP	
	☐ Support clinicians with referrals, scripts, and bookings	
	☐ Set **automated reminders** (BP/MD, Hotdoc, AutoMed, Healthengine)	
	☐ Establish / review your process for booking reviews & managing missed appointments	

Step 6	Actions	Assigned to
Monitor, Reflect, and Celebrate	☐ Use **QI tools to track** CCM transition activities (e.g., PDSAs, data reviews)	
	☐ Monitor registration targets and plan review timelines	
	☐ Regularly review and update all documentation	
	☐ Review your video telehealth setup for MyMedicare (consider using -create a **Healthdirect** account or **login**)	
	☐ Celebrate milestones and successes with your team	

Adapted from: Brisbane North PHN and West Vic PHN

CALL TO ACTION

Do a PDSA - Team awareness, desire and readiness

The infographic below depicts an example of management planning for a chronic condition patient. Review appointments as clinically relevant support ongoing patient engagement and care continuity.

CCM Management Plan Review example

Aims of chronic condition management plans are to provide a framework for personalised, coordinated care that empowers individuals to better self-manage their chronic conditions. Delivery of care should be underpinned by principles of dignity, respect and compassion.

Initial Chronic Condition Management Plan.

Provide updated copy to all care team members and the patient.

Review of management plan **as clinically relevant** up to every 3 months.

Reasons for review appointments could include:

- support the patient to understand and self-manage their chronic condition
- monitor symptoms and health,
- review and update medications,
- plan, conduct and review tests and screening
- update treatment plans in response to changes to patient needs, treatment options and evidence.