Gold Coast Chronic Condition Management

Continuous Quality Improvement Toolkit

The Chronic Conditions Management (CCM) QI Toolkit provides a practical guide to help general practices implement continuous Quality Improvement (QI) activities for managing chronic conditions.

It supports primary care teams in delivering structured, proactive, and person-centred care - enhancing continuity, improving patient outcomes, and increasing efficiency. The toolkit aligns with the revised CCM MBS items and the Strengthening Medicare reforms.

phn NATIONAL IMPROVEMENT NETWORK COLLABORATIVE
An Australian Government Initiative

National MyMedicare PHN Implementation Program

phn COOPERATIVE
An Australian Government Initiative

phn GOLD COAST
An Australian Government Initiative

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

Artwork: Narelle Urquhart. Wiradjuri woman.
Artwork depicts a strong community, with good support for each other, day or night. One mob.

Acknowledgements
This QI toolkit has been developed by Gold Coast PHN and PHN's nationally through the PHN Cooperative, the National Improvement Network Collaborative (NINCo), and the National MyMedicare PHN Implementation Program.

This resource was developed with the support of WentWest, Western Sydney Primary Health Network (PHN).

We acknowledge that some resources used or referenced within this toolkit are from organisations including the Department of Health, Disability and Ageing (DOHDA), Services Australia, Royal Australian College of General Practitioners (RACGP); Best Practice; and Medical Director. These organisations retain copyright over their original work. Referencing of material is provided throughout.

Where to get help?

Gold Coast Primary Health Network
07 5635 2455
practicesupport@gcphn.com.au

Appendices

Navigation

5.1 Quality Improvement documentation

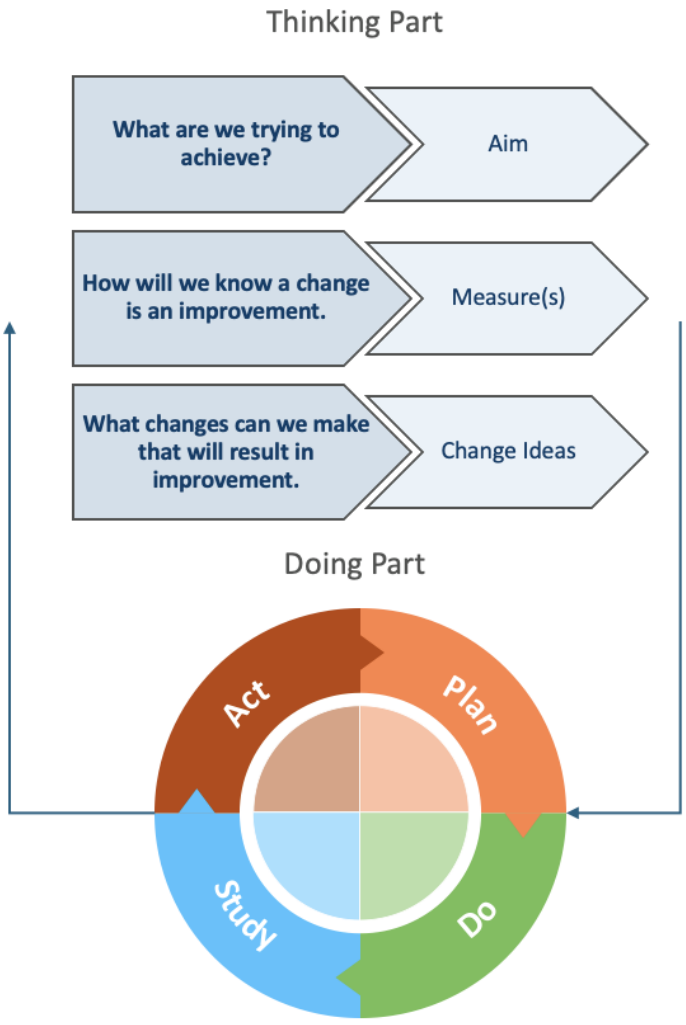
Start by documenting your **practice QI team** and define your problem and specified a robust ***Problem Statement.***

Practice name:	*Add your primary healthcare service name here*	**Date:**	Start date
QI team:	*List the team members involved*		
Problem:	*Describe why this work is strategically important. What problem is the team addressing? What does our data indicate about it, and what are the causes?*		
Problem Statement:	*Document your succinct problem statement here*		

Next, move onto the **Model for Improvement (MFI)**, the **'Thinking Part'** focuses on the overall improvement strategy, while the **'Doing Part'** implements changes through the **Plan-Do-Study-Act (PDSA) cycle**. This model uses PDSA cycles to test changes, ensuring measurable and sustainable improvements. Watch short video on MFI and PDSA's.

Step 1: Model for Improvement (Thinking Part)

1. **Goal / Aim:** What are we trying to accomplish? Develop a S.M.A.R.T. (Specific, Measurable, Attainable, Realistic, Time-bound) and people-crafted Aim Statement.
2. **MEASURE:** How will we know that a change is an improvement? Identify what good looks like and develop a measure(s) of success.
   Tip: *Use a* ***Run Chart*** *to plot trends*
3. **CHANGE IDEAS:** What changes can we make that will result in an improvement? Engage the whole team in formulating change ideas *using* ***Institute for Healthcare Improvement QI tools*** such as brainstorming, ***driver diagrams*** or ***process mapping***
   Each change idea may involve multiple small rapid PDSA cycles.



Step 2: Plan-Do-Study-Act (PDSA) (Doing Part)

1. **PLAN:** Describe the change idea (what, who, when, where). Predict outcomes and define the data to collect.
2. **DO:** Carry out the plan. Collect data. Consider what worked well and why? Document any unexpected observations, events or problems.
3. **STUDY:** Analyse results, compare them to predictions, and reflect on what you learned.
4. **ACT:** Based on what you learned from the test, consider what you will do next (e.g., adopt, adapt or abandon)? How does this inform the plan for your next PDSA?

For guidance, download template or for support on conducting quality improvement in your primary healthcare services, please contact your Primary care Deliver team on practicesupport@gcphn.com.au

Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA

QI ACTIVITY GOAL EXAMPLE

Develop and apply systems for patient recalls and reminders to enhance in MyMedicare registration, Care Planning and the importance of frequent reviews to enhance chronic conditions management.

Measure – How will you measure the change for this activity?

Overall measure

- Percentage increase in patients registered to MyMedicare in PRODA.
- Percentage patients on a care plan and aware of coming changes e.g. documented recent conversation with a member of the care team.

Baseline measures

Practice has xxx patients on previous care plans at the start of the activity. Following this activity and in preparation for the changes to CCM now have identified an additional XXX number of patients who should be on a care plan. XX% of patients are registered with MyMedicare.

Data to collect

Data will be collected on the following on the first Tuesday of the month for 6 months.

- Percentage rates of MyMedicare patients.
- Number of patients who are coming in for new CCM Care Plan or review to previous care plan?
- Number of patients with a note in their patient record that they have been made aware of the coming CCM changes.

5.2 PDSA – Team awareness, desire and readiness

Model For Improvement (MFI)

AIM	1. What are we trying to accomplish?
To increase awareness and understanding among the practice team about MyMedicare and Chronic Conditions Management (CCM) changes, while defining and documenting each team member's roles and responsibilities. This will help build readiness for change and support sustainable implementation.	
MEASURE(S)	**2. How will we know that a change is an improvement?**
• **Team members can describe the purpose and benefits of MyMedicare and CCM changes.** • **Documented and agreed team roles and responsibilities.** • **Feedback from the team shows increased confidence and clarity.** • **Team reflects on the process and adapts based on shared learnings.**	
CHANGE IDEAS	**3. What changes can we make that will result in improvement?**
Idea 1	Hold a team meeting or lunch catch-up to communicate MyMedicare and CCM changes
Idea 2	Share updates via email or in the staff room.
Idea 3	Use talking points to explore MyMedicare benefits.
Idea 4	Facilitate discussion around CCM changes and training needs.
Idea 5	Define, document, and review team roles and responsibilities regularly.
Next steps:	*Each idea may involve multiple short and small PDSA cycles.*

Plan-Do-Study-Act (PDSA)

Idea	Plan	Do	Study	Act
1.1	raise awareness about MyMedicare across the practice team. • Organise a 15–30 min team meeting or informal lunch session. • Share talking points and benefits of MyMedicare beforehand. • Pose open questions for discussion. Who: Practice manager and GP lead When: Week 1 Where: Staff meeting room	Held the meeting, provided handouts, and facilitated discussion on MyMedicare benefits and how it may impact the practice.	• Team showed interest but had questions about patient eligibility and enrolment. • Some team members unaware of how it aligns with the practice's current strategy. • Quick post-meeting feedback collected showed 80% of attendees found the session useful.	• Plan a follow-up FAQ session. • Add a MyMedicare summary to the practice resource folder. • Ensure key updates are emailed post-session.
1.2	Clearly define and document each team member's role in CCM and MyMedicare.: • Use provided role template. • Hold short 1:1 discussions with each staff member or in a small team huddle. • Document and share consolidated roles with the team. Who: Practice manager When: Week 2–3 Where: In-practice meetings	Met with all team members. Used the role template to draft roles and responsibilities. Shared draft with staff via email for feedback.	• Most team members appreciated the clarity. • A few roles needed adjusting after real-world testing. • Team identified gaps in CCM training during reflection.	• Schedule 4-week check-in to reflect on roles. • Organise a short training session on CCM planning. • Update and re-share finalised roles document.

5.3 PDSA – Identifying Active Patients and Linking to MyMedicare Program

Model For Improvement (MFI)

AIM	4. What are we trying to accomplish?		
Improve the accuracy of active patient identification and ensure 10% of eligible active patients are registered for the MyMedicare program within the next six months.			
MEASURE(S)	**5. How will we know that a change is an improvement?**		
Percentage of active patients identified who are successfully registered with MyMedicare.			
Baseline:	4000 active patients and 50 registered with MyMedicare	**Baseline date:**	10/11/2023
CHANGE IDEAS	**6. What changes can we make that will result in improvement?**		
Idea 1	Hold a team meeting or lunch catch-up to communicate MyMedicare and CCM changes		
Idea 2	Share updates via email or in the staff room.		
Idea 3	Use talking points to explore MyMedicare benefits.		
Idea 4	Facilitate discussion around CCM changes and training needs.		
Idea 5	Define, document, and review team roles and responsibilities regularly.		
Next steps:	*Each idea may involve multiple short and small PDSA cycles.*		

Plan-Do-Study-Act (PDSA)

Idea	Plan	Do	Study	Act
1.1	Practice Manager to extract a list of patients flagged as active patients who are not registered for MyMedicare by 1/11/23. **Prediction:** there will be patient that are inactive.	Conduct the first round of active patient verification for 50 patients and 10 were inactive as predicted. 15 were enrolled but MyMedicare status was missing. Update records to correct status and register them for MyMedicare.	• Conduct a bulk archive of inactive patients. Bulk import MyMedicare enrolments to PMS instead of manual/ per patient. Incorporate MyMedicare enrolment discussions during patient contact and pre-plan for upcoming appointments	Practice Manager to extract a list of patients flagged as active patients who are not registered for MyMedicare by 1/11/23. **Prediction:** there will be patient that are inactive.
1.2	Conduct a bulk archive of inactive patients **Prediction**: need to this regularly.	Conduct the first round of active patient verification for 50 patients and 10 were inactive as predicted. 15 were enrolled but MyMedicare status was missing. Update records to correct status and register them for MyMedicare.	• Conduct a bulk archive of inactive patients. Bulk import MyMedicare enrolments to PMS instead of manual/ per patient. Incorporate MyMedicare enrolment discussions during patient contact and pre-plan for upcoming appointments	Practice Manager to extract a list of patients flagged as active patients who are not registered for MyMedicare by 1/11/23. **Prediction:** there will be patients that are inactive.

5.4 PDSA – CCM and MyMedicare

Model For Improvement (MFI)

AIM	1. What are we trying to accomplish?
Improve the completion of management plans for MyMedicare-registered patients with chronic conditions by 20% in the next 3 month.	
MEASURE(S)	**2. How will we know that a change is an improvement?**
Proportion of chronic condition patients who are registered with MyMedicare and have an active care plan.	
CHANGE IDEAS	**3. What changes can we make that will result in improvement?**
Idea 1	Display MyMedicare posters in waiting areas and train all staff to engage patients in conversations about MyMedicare.
Idea 2	Use data tools (e.g. Primary Sense) to identify patients with chronic conditions who are not yet registered with MyMedicare.
Idea 3	Send SMS or letters to identified patients, outlining the benefits of MyMedicare and management plan eligibility.
Idea 4	Flag eligible patients in the practice management system to prompt MyMedicare discussions during appointments.
Next steps:	*Each idea may involve multiple short and small PDSA cycles.*

Plan-Do-Study-Act (PDSA)

Idea	Plan	Do	Study	Act
1.1	Practice Nurse to flag patient files of those likely to benefit from MyMedicare registration. Practice Manager to ensure all staff are trained and equipped with key messages for patient conversations. ***Prediction:*** *Flagging and staff messaging will increase MyMedicare registrations.*	Begin flagging eligible patients in the system. When these patients attend appointments, GPs initiate discussions about MyMedicare. Share informational materials via email or print.	Monitor staff feedback and patient responses. Record the number of patients flagged, engaged, and successfully registered. Identify any challenges or missed opportunities.	Adjust flagging or scripting processes as needed. Refine communication methods (e.g. SMS vs. in-person). Plan next PDSA cycle to build on what worked well.
2.1	Conduct a **data cleansing** exercise using Primary Sense to identify patients with diagnosed or potentially undiagnosed chronic conditions. ***Prediction:*** *improved patient identification*	Reviewed 50 patient records (e.g. diabetes cohort) to verify diagnoses and uncover inconsistencies or missing coding.	There may be some discrepancies or missing data points in the initial search results, particularly if the chronic conditions are under-diagnosed or not appropriately coded (see **Indicated Diagnoses report)** . This will require follow-up with clinicians to ensure correct data entry and comprehensive patient records.	Standardise coding practices within the PMS. Use Primary Sense condition **Data Mapping** Train staff to enter coded diagnoses (no free text) and use provisional diagnosis fields appropriately. Scale this activity to broader cohorts.
2.2	Train clinical staff on accurate coding procedures using Primary Sense, Best Practice, and Medical Director tools. Prediction: improved management plan eligibility identification. ***Prediction:*** *Training will improve coding accuracy and management plan eligibility.*	Delivered staff training sessions. Provide resources and visual guides. Introduce standardised coding templates.	Track updates in chronic disease coding and increases in accurately coded diagnoses. Review feedback from clinicians.	Continue refining training materials. Monitor coding trends monthly. Use coding data to trigger management plan reminders and patient recalls.
3.1	Use Primary Sense to identify MyMedicare-registered patients due for a GPMP/TCA. Aim to optimise both management planning and MBS claiming. ***Prediction:*** *Recalls will boost attendance*	Review a sample list of 50 patients with diabetes. Initiate recalls via SMS, phone, or opportunistic prompts during visits.	Assess how many patients responded to recalls and completed management plans. Document process issues or patient feedback.	Refine recall messaging and intervals. Introduce automated reminders and integrate review scheduling into routine workflows.

5.5 PDSA – Reducing Missed Appointments for Management plan reviews

Model For Improvement (MFI)

AIM	1. What are we trying to accomplish?
Reduce missed chronic condition management plan review appointments by 20% in the next 3 month.	
MEASURE(S)	**2. How will we know that a change is an improvement?**
➢ Reduction in missed chronic condition review appointments (target: 25% reduction over 6 weeks). ➢ Increase in rebooked review appointments. ➢ Increase in patient engagement with digital education materials (e.g., GoShare). ➢ Number of patients with documented personalised care goals.	
CHANGE IDEAS	**3. What changes can we make that will result in improvement?**
Idea 1	Implement structured follow-up processes (calls, letters) for missed appointments using tracking tools like BP, Pracsoft, or Cubiko.
Idea 2	Assign a nurse or designated team member to track and rebook missed reviews.
Idea 3	Use GoShare or similar platforms to re-engage at-risk patients through videos and resources.
Idea 4	Introduce personalised, patient-centred goals into management planning to boost motivation and follow-up rates.
Next steps:	*Each idea may involve multiple short and small PDSA cycles.*

Plan-Do-Study-Act (PDSA)

Idea	Plan	Do	Study	Act
1.1	Develop a structured follow-up workflow using BP and Cubiko to identify and act on missed chronic condition reviews. Create standard letter and call templates. ***Prediction:*** *A consistent follow-up process will reduce missed appointments by at least 20% within 6 weeks.*	Trial the process for 4–6 weeks with admin staff using the templates to follow up with patients who missed reviews.	Monitor reduction in missed appointments. Cubiko showed a 25% reduction over 6 weeks. Staff reported more confidence in consistency of follow-up.	Adopt the follow-up process as policy. Train all admin staff. Automate reporting and follow-up tracking in Cubiko or equivalent system.
2.1	Test whether having a nurse or admin staff responsible for tracking missed reviews improves rebooking outcomes. ***Prediction:*** *Assigning a nurse to manage rebooking will improve review attendance rates compared to ad hoc admin follow-up.*	Trial with rotating admin and nursing staff for 4 weeks. Track rebooked patients.	Nurse-led follow-up achieved higher rebooking rates compared to admin-only. Fewer patients were lost to follow-up.	Assign this task permanently to nursing staff, with admin backup. Document responsibilities in staff workflows.
2.2	Use GoShare to send targeted educational videos/resources to patients who have missed reviews or show signs of disengagement. ***Prediction:*** *Sending GoShare resources will re-engage at least 40% of patients who previously missed their review appointment.*	Send GoShare resources to at-risk patients. Monitor engagement using platform analytics.	~45% engagement rate. Patients who interacted with content were more likely to rebook and attend their next appointment.	Expand GoShare use to other cohorts (e.g. mental health, lifestyle conditions). Develop SOPs for using digital resources when disengagement risk is flagged.
3.1	Introduce patient-centred goal-setting (e.g. weight, activity, mental health) during care plan reviews to improve follow-through. ***Prediction:*** *Patients with documented personal goals will be more likely to attend follow-up reviews and report higher satisfaction.*	Implement this with a small cohort of patients during routine reviews. Document goals in the care plan.	Patients with personalised goals showed improved motivation and better follow-up attendance. Positive feedback was noted from nurses..	Incorporate personalised goals into all care plan templates. Use Primary Sense reports to monitor patient progress monthly.

5.6 Measuring Outcomes – Audit Worksheet

1. Choose the QI activity measure that aligns with your practice goal
2. Enter a practice target and baseline for each QI activity measure in the table below
3. Track your progress over time by entering a result for reporting period.
4. Use run chart to plot results over time.

Measure:	Practice Target	Baseline date	Result 1 date	Result 2 date	Result 3 date	Result 4 date
Example PIPQI	# (%)	%	# (%)	# (%)	# (%)	# (%)
MyMedicare registered patients						
MyMedicare registered and CCM patients						
Patients due for CCM or review						
Patients with 'Diabetes'						
Patients with a billed Care Plan in the past 12 months						
Insert QI activity measure						
Insert QI activity measure						
Insert QI activity measure						

** Per RACGP, an active patient has 3+ visits in 2 years. This filter may exclude new or at-risk patients who don't see their GP regularly*

5.7 Group reflection – after completing activities

As a team, analysis and review baseline data results and discuss change ideas and actions. Use PDSA cycles to test and measure change ideas	
The degree to which the learning needs were met: Not met Partially met Entirely met	To what degree this activity was relevant to your practice: Not met Partially met Entirely met
What did you learn? What changes would you make to your practise as a result?	
For example, • Has patient engagement increased through education efforts? • Which educational strategies were most effective? • Have MyMedicare registrations improved following engagement efforts? • Do relevant team members know how to send out GoShare patient resources, videos and apps? • What barriers were encountered in patient engagement?	
RACGP CPD: utilise the self-reporting feature on Quick Log mycpd.racgp.org.au to document reflection.	

5.8 Useful contacts

Gold Coast PHN	07 5612 5408 | practicesupport@gcphn.com.au www.gcphn.org.au Engagement Officer flyer
Provider Digital Access (PRODA) PRODA	1800 700 199 (option 1) | proda@servicesaustralia.gov.au PRODA Information Training: PRODA eLearning
Health Professional Online Services (HPOS)	132 150 (option 6) HPOS Access Training: HPOS eLearning
Medicare Provider Enquiries (Medicare Programs)	Phone: 132 150 (Option 2 - Claiming, payment, Provider Registration, MyMedicare and Organisation Register enquiries)
Services Australia Incentive Program	1800 222 032 Incentive Program Information Training: Incentive Programs eLearning
MBS	13 21 50 | askmbs@health.gov.au MBS online Training: MBS Training eLearning
Healthdirect	1800 580 771 | videocallsupport@healthdirect.org.au Registration Form Video Call Video Call
Australian Immunisation Register	1300 650 039 air@humanservices.gov.au
Department of Veteran Affairs	1800 550 457
Services Australia eBusiness	1800 700 199 ebusiness@humanservices.gov.au
Primary Sense	07 5612 5476 | primarysense@gcphn.com.au www.primarysense.org.au
Medical Director	1300 300 161 www.medicaldirector.com
Best Practice	1300 40 1111 | support@bpsoftware.net www.bpsoftware.net
Translating and Interpreting Service (TIS National)	131 450
My Aged Care	1800 200 422
MyGov help desk	132 307 - option 1
eRx	1300 700 921
Healthlink	1800 125 036
My Health Record	1800 723 471
Gold Coast Hospital and Health Service – GP Advice Line	1300-004-242 (option 3) | GCGPLU@health.qld.gov.au *- please ensure you de-identify patient information if sending by email. Only provide the initials of your patient's name and date of birth. Available Monday to Friday, 8am to 4pm.*
Gold Coast Public Health Unit	(07) 5667-3200 | GCPHU@health.qld.gov.au *(do not include any patient information)* For after hours health advice, phone 13 HEALTH (13 43 25 84)
Medicare Urgent Care Clinic	Southport 07 5680 0040 | Oxenford 07 5573 1122 www.gcphn.org.au/medicare-urgent-care-clinic

5.9 MBS Quick Guide

This guide outlines the frequently used Medicare Benefits Schedule (MBS) items with each item number linked MBS criteria, descriptor and fact sheets. **Click here** for a full list of MBS items.

MBS ONLINE
- Search for Item Number
- Fact Sheets
- Updates (XML Files)
- MBS News

ELIGIBILITY
Ensure patient meets billing criteria.
- HPOS MBS checker
- My Health Record

MORE INFORMATION
- www.mbsonline.gov.au
- Contact MBS 13 21 50 askMBS@health.gov.au
- Gold Coast HealthPathways - MBS Items

CHRONIC CONDITIONS MANAGEMENT (CCM)	Face to Face	Telehealth*
GP chronic condition management plan** (EVERY 12 MONTHS if clinically relevant)	965†	92029†
GP chronic condition management plan Review** (EVERY 3 MONTHS if clinically relevant)	967†	92030†
Practice Nurse /Aboriginal Health Practitioner follow-up services for a patient with a chronic condition (5 PER YEAR)	10997	Phone 93203 Video 93201
Practice Nurse/Aboriginal Health Practitioner follow-up services for Aboriginal and Torres Strait Islander patients (10 PER YEAR)	10987	Phone 93202 Video 93200
Domiciliary Medication Management Review (DMMR) (ANNUALLY)	900	
GP contribution to multidisciplinary plan – Community (EVERY 3 MONTHS)	729	92026
GP contribution to multidisciplinary plan (MCP) – RACF (EVERY 3 MONTHS)	731	92027
Residential Medication Management Review (RMMR) (ANNUALLY)	903	
† MyMedicare registered patients can only access these services at their MyMedicare general practice *Telehealth (Video Consults) and *Telephone (Phone Consults) available to Medicare-eligible patients with an established practice relationship who have attended in-person within the past year can access services. (Exceptions include children under 12 months, COVID-19 isolation, natural disaster areas, Aboriginal Medical Services, urgent after-hours care, homelessness, or services for blood-borne viruses, sexual/reproductive health, or TOPIC. The 30/20 rule applies to telephone items.) **Patients with a General Practitioner Chronic Disease Management Plan/Review can access the following MBS services: • Allied Health Services: Up to 5 individual sessions per year (10 for Aboriginal or Torres Strait Islander patients). • Nurse or Health Practitioner Services: Up to 5 services annually, provided on behalf of a doctor. • Type 2 Diabetes Care: If eligible, up to 8 yearly group sessions for dietetics, education, or exercise.		

CASE CONFERENCING			
Case Conference GP organises (MAX. 5 TIMES PER PATIENT PER CALENDAR YEAR)	735	739	743
Case Conference GP participating (MAX. 5 TIMES PER PATIENT PER CALENDAR YEAR)	747	750	758

BULK BILLING INCENTIVES (BBI)	
BBI (**MBS MN.1.1**) can be claimed when you bulk bill a child under 16 or a **Commonwealth Concession Card** holder. Expanding eligibility for **Medicare bulk billing incentives** takes effect 1 Nov, 2025.	
MyMedicare enrolled patients only at their enrolled practice • **Level C, D, E (Telehealth*)** • **Level C, D (Telephone*)**	75880†
• **Level B, C, D, E (Face to Face)** • **Level B (Telehealth*, Telephone*)**	75870
All other eligible services not covered below (refer MBS MN.1.1)	10990

To ensure your practice software applies the correct Bulk Billing Incentives, make sure MyMedicare status is updated regularly.

phn
NATIONAL IMPROVEMENT NETWORK COLLABORATIVE

An Australian Government Initiative

Level 1, 14 Edgewater Court Robina QLD 4226 | PO Box 3576, Robina Town Centre QLD 4230
P 07 5635 2455 | E ninco@gcphn.com.au | W www.ninco.com.au

National Improvement Network Collaborative (NINCo) gratefully acknowledges the financial and other support from the Australian Government Department of Health. While the Australian Government Department of Health has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Australian Government and is not advice that is provided, or information that is endorsed by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage however arising from the use or reliance on the information provided herein.

092025/092026