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.

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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
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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
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Module 1

Leadership - Preparing your practice

On completion of this module, you will:

- Evaluate your practice's readiness to implement MyMedicare and Chronic Condition Management
- Engage the entire practice leadership team to confirm MyMedicare registration status and ensure readiness for the transition

Activity Navigation

1.1 Practice Readiness Checklist
1.2 Preparing for CCM QI in action
1.3 Communication Action Plan
1.4 Practice Change (QI) Plan
1.5 Practice Meeting template

MyMedicare and Chronic Conditions Management (CCM) Foundations

MyMedicare is a Voluntary Patient Registration (VPR) model that connects patients with their preferred general practice and care team to promote continuity and comprehensive care.

By choosing a MyMedicare practice, patients formalise where GPCCMP MBS items can be accessed. This connection strengthens relationships and ensures proactive care planning for long-term conditions.

Eligible Patients registered with MyMedicare can only access GP Chronic Condition Management Plan services (face-to-face or telehealth) at their MyMedicare registered practice location, delivered by any eligible provider (including GP registrars) there, not other practices or locations.

Chronic Conditions MBS items support primary care providers to develop plans and continue to actively manage, monitor, and coordinate ongoing care with other providers working as a multidisciplinary team, for patients diagnosed with a chronic condition that is expected to impact their health for longer than 6 months.

GPCCMP items also support access to allied health and other services for patients that would benefit from multidisciplinary team care to manage their chronic condition.

For more information, refer to the **Services Australia Fact Sheet – Overview of MBS Changes**

MyMedicare Practice Registration

- Link your organisation in **PRODA** to **HPOS**
- Access the **Organisation Register** in **HPOS** to register your practice and link your eligible health care providers
- Add MyMedicare to 'My Programs' in HPOS
- Ensure practice staff have appropriate delegations to access MyMedicare on HPOS

Learn more:

- **Service Australia's MyMedicare**

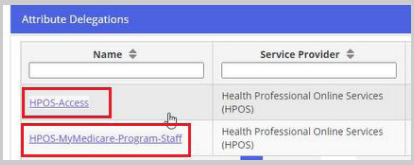
Practice Resources

- **CDM Changes – Overview**
- **CDM Changes – Transition Arrangements**
- **CDM Changes – Referral Arrangements**
- **CDM Changes – GPCCMP MBS Items**
- **CDM Changes – Allied Health Providers**
- **CDM Changes – Practice nurse, Aboriginal**
- **Health workers and ATSI Health Practitioners**
- **MyMedicare - Service Australia e-learning**
- **RACGP summary of CCM changes**
- **MyMedicare - Translated resources**
- **MyMedicare - GP Communication Toolkit**
- **MyMedicare - Practices and providers**
- **Chronic Condition Management Items Gold Coast Health Pathways**
- **RACGP - Chronic disease**
- **RACGP – Preventive Activities (the Red Book)**

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.

1.2 Activity - Preparing your practice for CCM QI Action

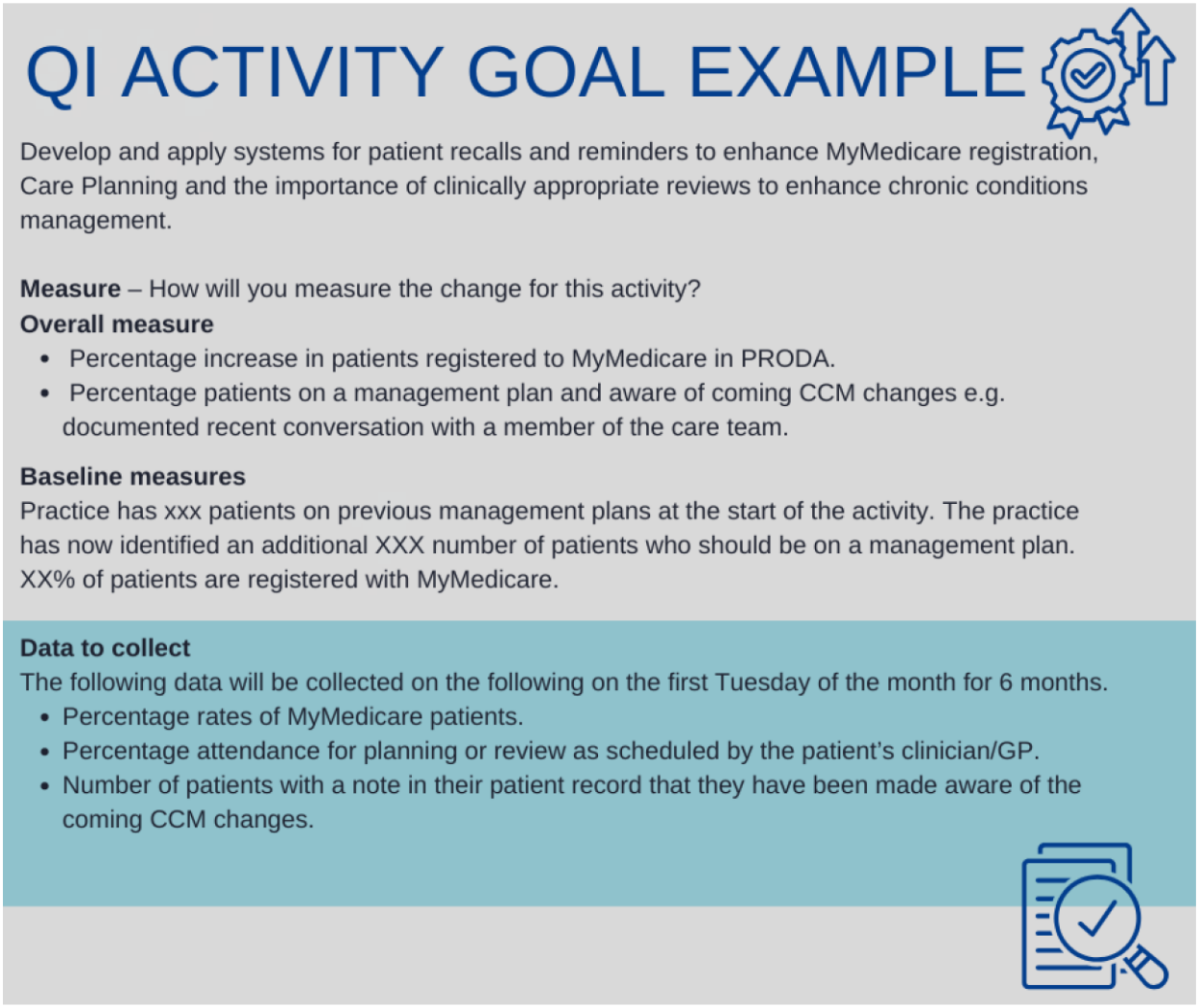
A systematic approach to defining team roles, engaging patients, and quality improvement is necessary for successful Chronic Condition Management (CCM).

Every successful Quality Improvement starts with setting clear goals, underpinned by data and requires ongoing measurement and cycles of new activity in response to your findings. This process engages your primary health care team in assessing progress and tracking if change(s) are leading to an improvement.

Demonstrating the impact of your team's QI actions is essential to maintaining engagement, momentum and building a culture of celebrating success!

It is best to measure at the beginning of the activity (baseline) and then at regular intervals. Use the **Model for Improvement (MFI) framework** to methodically work through identifying a clear problem, and to explore solutions and take action.

The QI Activity Goal below is an example of a clear goal for Chronic Conditions Management and MyMedicare you could adapt to your practice.



1.3 Activity – Communication Action Plan

Practice name:

QI focus area	Why improve this focus area?	QI ideas "What" of the action plan	Resources

MyMedicare Patient Registration
 	
To increase patient registration for MyMedicare for our General Practice
	What are the benefits of undertaking activities in this area?
	
	• Opportunity to formalise, establish or enhance our relationship for ongoing coordinated care with patients
	• To prepare for Chronic Conditions Management (CCM) MBS item changes
	• To prepare for changes to Better Access Mental Health Treatment Plans
		What ideas can we explore?
		
		Tips for engaging patients:
		• Encourage registration as they present to the practice or attend appointments including patient who have:
		  • attended the practice twice in 24 months
		  • attend the practice for ongoing care management (e.g. Chronic Disease Management Plans, Mental Health Treatment Plans, Health Assessments and Health Checks)
		
		Communication approaches/ideas
		• Posters or flyers - waiting room and reception
		• Website and/or social media
		• Targeted identification - Search and tag patient records for action when they present or contact the practice
		• Encourage patients to register through Medicare Online Account
		• Conversations at appointments including reminder cards, information in clinic rooms.
		• SMS or email campaign
		• MyMedicare patient forms offered to patients (notepaper forms submitted through PRODA require additional staff time required to process)
		• Poster documenting your unique MyMedicare value or key messages
			Clinic resources
			
			1. MyMedicare GP Toolkit (includes posters, social tiles, flyers, etc)
			2. MyMedicare Videos
			3. Introducing MyMedicare – Fact sheet
			4. Registering in MyMedicare – Fact sheet
			5. MyMedicare practice registration – Frequently asked questions
			6. Registering patients with MyMedicare – Systems overview for practices and providers
			7. MyMedicare Program Guidelines
			8. About MyMedicare for health professionals

1.4 Activity – Practice Change (QI) Plan

Please complete the following table to outline your plan to complete the goal.

Engaged Leadership	**Goal**	**Improve chronic condition management by focusing on MyMedicare registration in *[insert time frame]* from ##% (*## patients*) to ##% (*## patients*) by DD/MM/YYYY.**		
	Measure/s	• number of patients MyMedicare registered • number of patients on the chronic conditions register • number of management plans/reviews billed • number of appointments (missed, rebooked)	**Search criteria**	
	QI Lead and Team	Who will need to be involved?	**Period**	Start date - end date

	Actions *Tip: Use PDSA cycles to test change ideas*	**Activity**	**Resources**	**Who**	**Period**	**Update**
Data-Driven Improvement	Conduct **data cleansing** to identify and verify patients with MyMedicare status and chronic conditions.		• Data Cleansing Toolkit		Start date - end date	Allocated a usual care provider to patients
	Identify your MyMedicare and CCM patients using Primary Sense and document baseline data		• Primary Sense			
Patient Registration	**Find eligible patients that are due for management plan/ review**		• Primary Sense			
	Ensure **recall and reminder system** is established for MyMedicare and CCM patients		• BP Reminder • MD Recalls			
	Educate patients on CCM management plan and review benefits					
	Communicate and promote MyMedicare and CCM					
Team-Based Care	Identify **roles and responsibilities**					
	Map workflows and upskill team in MyMedicare and CCM					
	Assign a nurse or admin staff to **track and rebook missed appointment**					
	Train clinical staff to enter **coded diagnoses** (no free text)					
	Ensure staff can access **HealthPathways** for the latest chronic conditions assessment, management and referral information		• Gold Coast HealthPathways			
	Create **patient-centred goals** with more frequent reviews					

Reflection	**Outcomes Summary**	As a team, what did you learn? What changes would you make to your practice as a result?
		RACGP CPD Tip: utilise the self-reporting feature on Quick Log **mycpd.racgp.org.au** to document reflection.

1.5 Activity – Practice Meeting template

The most common way for practices to build teamwork is to schedule regular meetings where all members of the practice team are encouraged to contribute to discussions. It is a good idea to keep minutes of the meetings and to document the decisions made at team meetings and the names of those responsible for implementing related actions.

A Practice Meeting needs between 2-25 participants (GPs, practice staff and other health professionals) with each meeting lasting at least 30mins, in order to meet CPD activity requirements.

< Practice Meeting Title>

Please note:

- *(C0.0▸C, QI0.0A) is RACGP Standards for General Practices – 5th edition indicator*
- *RACGP CPD type: Educational Activities (EA), Reviewing Performance (RP), Measuring Outcomes (MO)*

PRACTICE		**Date:**	
CHAIR (GP/Practice Lead)		**Time:**	
Participant names			
Agenda/ Topics	**Actions/ Summary** – Example	**CPD Type / Duration**	
1. Quality Improvement *(QI1.1 ▸B,C,D)*	• *This can include updates on QI projects such as MyMedicare,* ***Chronic Condition Management (CCM) change*** *ideas, coming together to discuss changing current processes to improve data, staff feedback on anything relating to the practice.* • *Making quality improvements to the practice's structures, systems and clinical care that are based on the practice's information and data will lead to improvements in patient safety and care.* *Quality Improvement includes:* • *Patient health records quality* • *MyMedicare/CCM project changes to the day-to-day operations of the practice, such as – scheduling of appointments – normal opening hours – record-keeping practices – how patient complaints are handled – systems and processes* • *Responding to feedback or complaints from patients, carers or other relevant parties* • *Responding to feedback from members of the practice team* • *Auditing clinical databases* • *Analysing near misses and errors* • *Practices –what QI is being implemented across the practice* ***MyMedicare Practice Registration:*** • *MyMedicare practice registration checklist* ***here.*** • *Adding GPs as providers to the Organisation Register in PRODA* ***here.*** • *Providing practice staff with relevant delegations to view and manage patient registration* ***here.*** • *Educating non-clinical staff on the steps involved in patient registration with your practice and preferred GP* ***here.*** ***MyMedicare Patient Registration:*** • *Patient facing resources to formalise the relationship between patient, general practice, and preferred GP* ***here.*** • *Patient eligibility and methods of registration* ***here.*** • *MyMedicare Patient Registration Form* ***here.*** ***MyMedicare and CCM Examples meeting resources:*** • *Patient registration benefits* ***here.*** • *MyMedicare General Practice Communication Toolkit* ***here.*** • *CCM MBS item changes – Overview here.*	RP 30mins	

	• *CCM MBS item changes – Transition Arrangements for Existing Patients* ***here.*** • *CCM MBS item changes – Referral Arrangements for Allied Health Services* ***here.*** • *CCM MBS item changes – MBS Items for GP Chronic Condition Management Plans* ***here.***	RP 30mins
2. Risk management including Clinical Risk ***(C3.1 ▸C, QI3.1A)***	*Have any staff identified any risks in the practice that should be addressed? If mentioned here, they should be placed in the risk register and addressed.* *Examples:* • *Poor record keeping* • *IT system failures* • *Inadequate systems for updating patients' contact details and following up test results* • *Workplace health and safety incidents, as a result of equipment that is not maintained in accordance with the manufacturer's recommendations* • *Inadequate number of practice staff working during busy times* • *Conflicts of interest/ethical dilemmas* • *Updates to or breaches of the IT security system.*	
3. Patient Feedback *(QI1.2 ▸B)*	*Depending if the practice collects feedback once every three years or on a continual basis will guide this agenda item. Either way this is a good time to address patient feedback and possibly ask the team if they have any solutions.*	
4. WHS ***(C3.5 ▸A)***	*Raising issues about the health and safety of the team. For example, are duress alarms required, how to deal with an aggressive patient.*	
5. Clinical Care of patient's ***(C5.1 ▸A,B)***	• *When clinical teams discuss clinical care, they must refer to and consider the best available evidence, to ensure their clinical care aligns with best practice. In some instances, 'best practice' may involve doing more than adhering to current clinical guidelines. Each team meeting there could be a new clinical topic, such as referral for a colonoscopy where patient symptomatic and urgency of referral are discussed* • *Specific patient cases can also be discussed at team meetings if patient confidentiality is maintained.*	
6. Other	• *Ethical dilemmas- These are then to be entered into an ethical dilemma log and the patient's files- C2.1 ▸E* • *Administrative matters- C3.4 ▸A* • *Infection control updates including changes to guidelines and laws.* • *An opportunity to announce local outbreaks and public health alerts - GP4.1 ▸A*	

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