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
07 5635 2455
practicesupport@gcphn.com.au

Module 4

Team-based care approach

On completion of this module, you will:

- Optimise care plan reviews to boost efficiency, outcomes and practice performance.
- Allocate team tasks to ensure clarity and ownership of each member's role.

Activity Navigation

Revised structure for chronic disease management items

From 1 July 2025, there is a revised structure for items for chronic disease management. The changes simplify, streamline, and modernise the arrangements for health care professionals and patients. These changes primarily affect medical practitioners, however, allied health professionals providing MBS services should be aware of the changes to the plan and referral requirements. Transition arrangements will be in place for two years to ensure current patients don't lose access to services.

Items for GP management plans (229, 721, 92024, 92055), team care arrangements (230, 723, 92025, 2056) and reviews (233, 732, 92028, 92059) will cease and be replaced with a new streamlined GP chronic condition management plan (GPCCMP). Table below - Chronic Condition Management items commencing 1 July 2025.

Name of Item	GP item number	PMP item number	Frequency of Claiming	Fee
Prepare a GP chronic condition management plan – face to face	965	392	Every 12 months if clinically relevant	GPs - $156.55 PMPs - $125.30
Prepare a GP chronic condition management plan - video	92029	92060	Every 12 months if clinically relevant	GPs - $156.55 PMPs - $125.30
Review a GP chronic condition management plan – face to face	967	393	Every 3 months if clinically relevant	GPs - $156.55 PMPs - $125.30
Review a GP chronic condition management plan – video	92030	92061	Every 3 months if clinically relevant	GPs - $156.55 PMPs - $125.30

The purpose of this resource is to support General Practices to plan their delivery of care for patients with chronic conditions and provide examples of how to use MBS items to provide regular care and review for patients in line with the intent of the 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

This resource demonstrates the potential use of MBS items related to CCM, for a full explanation of each MBS item please go to MBS online. https://www.mbsonline.gov.au/

4.1 Activity – Business Optimisation for CCM

The Chronic Conditions Management MBS changes support general practices to undertake proactive care planning, quarterly reviews, team-based follow-up and early intervention. General practices should consider, how best to support their chronic condition patients with self-management and care to improve outcomes for their chronic conditions whilst effectively claiming to optimise practice Medicare revenue.

Approach

As a practice or as a team (GP, practice nurse, AHP, NP etc.), determine the approach you will take to GPCCMP and optimising both atient outcomes and revenue.

- **Annual GPCCMP:** Developed and shared with the patient and care team.
- **Quarterly Reviews:** Assess goals, progress, symptoms, and update care as clinically required.
- **Nurse/AHP Follow-up Services:** Delivered ***up to 5 times annually*** to reinforce care plans and patient actions.

Nurses or AHP may provide support and follow up at the time of the management plan/ review appointment.

Alternatively, an approach may be for the nurse or AHP to provide a follow up phone call and support/ touch point with the patient to check in, confirm care plan goals, assist with allied health or any other referral pathways.

Either option the nurse or AHP can claim the MBS item 10997.

Revenue of one patient,
attending all review appointments

Service	Times/ Year	Annual amount billed/ patient	Annual amount billed/ patient
GPCCMP MBS 965 or 92029	1	$156.55	
GPCCMP Review MBS 967 or 92030	3	$469.65	
Nurse/ AHP follow up 10997 or 93203	3-5	$42.00 - $70.00	$667.15 - $691.45

Why Review

- Use **Care Planning Claiming workflow** to explore care plan contents.
- Care plan reviews enable timely adjustments to medications, referrals, and self-management strategies.
- Ultimately, working in partnership with patients for better outcomes leads to reduced hospital admissions.
- Working together, with your team and patient to provide planned care across a 12-month cycle of care, will have an improved revenue impact.

Operational Tips

- **Examine practice data -** know who your CCM patients are.
- **Determine a target -** % of patients rebooked for review appointments (include missed appointments and DNAs)
- **Engage your patients** so they are well informed and aware of the reason/s for their review appointment and what will happen at the next appointment.
- **Recall -** utilise practice systems to automate appointment reminders and recalls.
- **Flexibility -** ensure your practice is able to provide patient's access (flexibility may be key), face to face and/or telehealth may be required.

Refer MBS guide for the frequently used items including Care Planning and incentives This guide links item number to MBS criteria, descriptor and fact sheets

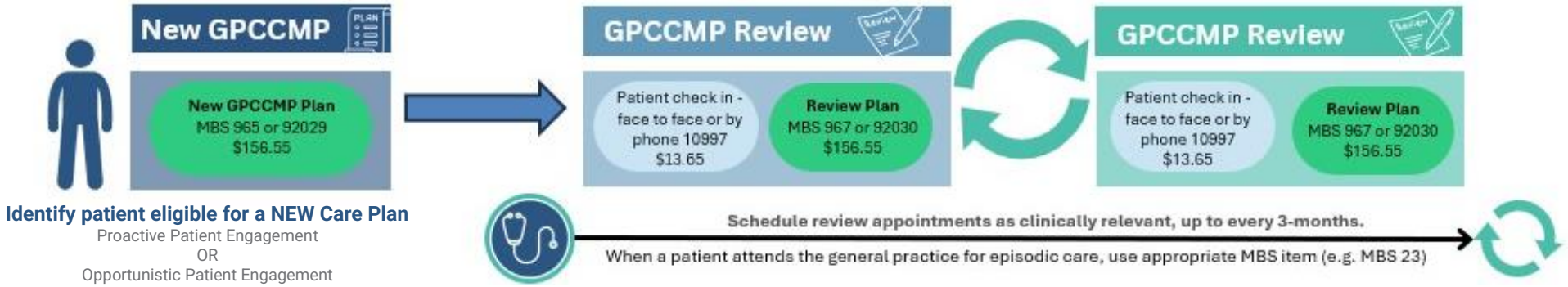
Bulk Billing Incentive & Bulk Billing Practice Incentive Program

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

- **From 1 November 2025, all Medicare-eligible patients will be eligible for bulk billing incentives.**
- **The CCM MBS items are eligible for Bulk Billing Incentive and Bulk Billing Practice Incentive Program items which attract additional payments.**
- **For more information on Bulk Billing Incentive changes click here**

4.2 Activity – CCM Claiming Annual Cycle of Care

Refer to the Chronic Conditions Management MBS User Guide for examples of how CCM management planning items can be used and claimed by general practices.



New GPCCMP

1. Patient Eligibility

- ☐ Must have at least **one chronic or terminal condition** (≥6 months). No age restrictions
- ☐ **MyMedicare status checked. Discuss MyMedicare patient registration to support care continuity with your practice.**

2. Develop the Management Plan ***- GP must see patient***

Practice Nurse, Aboriginal Health Workers, Practitioners may contribute to preparing the plan

- ☐ Explain the management plan process, gain informed consent, and collaboratively identify the patient's conditions, goals, actions, and required services.
- ☐ Discuss review visit frequency and importance.
- ☐ Refer to other providers as needed (**referral letters**, not TCAs).

3. Complete the Plan

- ☐ Record consent and provide copy of plan to patient and carer.
- ☐ **Set review timeline**—As clinically appropriate, up to **every 3 months**.
- ☐ Share plan with referred providers (with consent).
- ☐ Encourage upload to My Health Record (with consent).

4. Claiming

- ☐ Use correct item numbers (e.g. 965 for plan, 967 for review).
- ☐ All plan elements must be complete to claim.
- ☐ Claiming unlocks up to 5 Medicare-rebated allied health visits

General Practitioner and prescribed medical practitioner (PMP) items

Practice nurse/Aboriginal and/or Torres Strait Islander Health Practitioner items

Chronic condition management is an **ongoing care process** including regular management plan reviews as clinically required.

GPCCMP Review

- ☐ Review existing GPCCMPs every 3 months if clinically appropriate.
- ☐ Use MBS item 967 (face-to-face) or 92030 (video)
- ☐ Assess patient progress, update goals and services, obtain and record consent
- ☐ Share updates with other providers (if applicable)
- ☐ Schedule the next review.

4.3 Activity – Allied Health Referrals and other GPCCMP considerations

There are a wide range of services and considerations that can enhance management plans. **Consider your patient's unique wellbeing needs and lifestyle goals.** Refer to HealthPathways for evidence based clinical decision support to inform management planning for each chronic condition. More info, visit **HealthPathways**

Allied Health Referrals

Consider any allied health care your patient may require have when writing the management plan with them.

Referral letters to allied health providers, documenting the care required, consistent with the referral process for medical specialists.

Allied health providers are required to provide a written report back to the GP after the provision of services (e.g., the first service under a referral).

Referrals are valid for 18 months (unless stated otherwise by referring GP).

Other Management Plan Considerations

Blood Tests and other periodical tests

Scripts & other disease specific testing e.g., ECG, Peak Flow etc.

Medical Specialist referral if required

Specialist Nurse supports such as:
Breast Care Nurse, Continence Nurse, Renal Nurse, Respiratory, Cardiac etc.

Case Conference with care team
MBS 735, 739, 743, 747, 750, 758

Type 2 Diabetes Group Services Referral for Diabetes Education, Dietetics or Exercise Physiology

Self Management or Support Groups relevant to chronic condition

Family Support
Consider if family members/ carers require any supports.

Mental Health Support
Consider mental health needs for individual especially if a new diagnosis

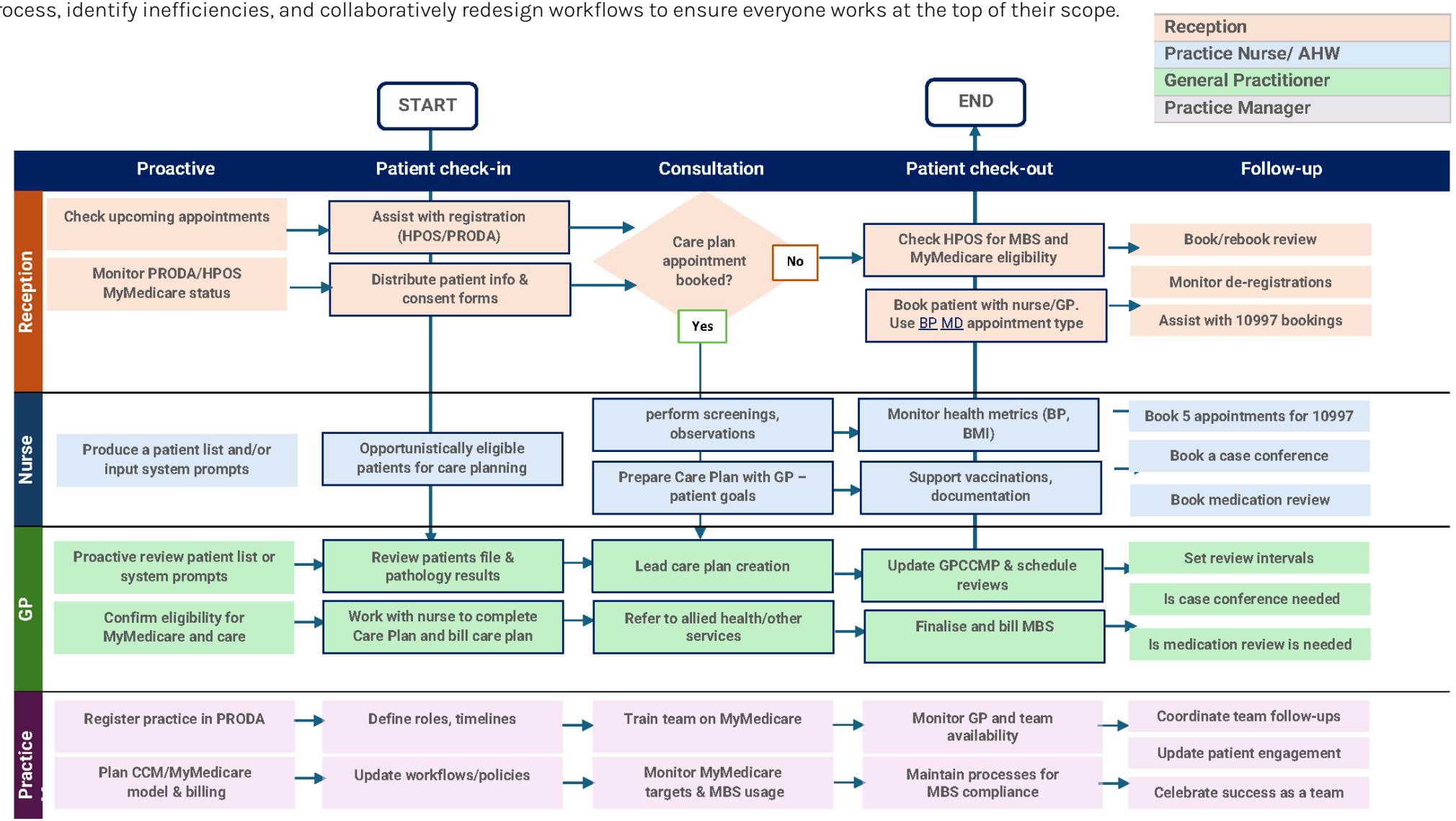
Social Work Referral
Consider this where there is social issues where additional support would benefit chronic condition outcome.

Social Prescribing
Consider if social prescribing may be appropriate for this patient.

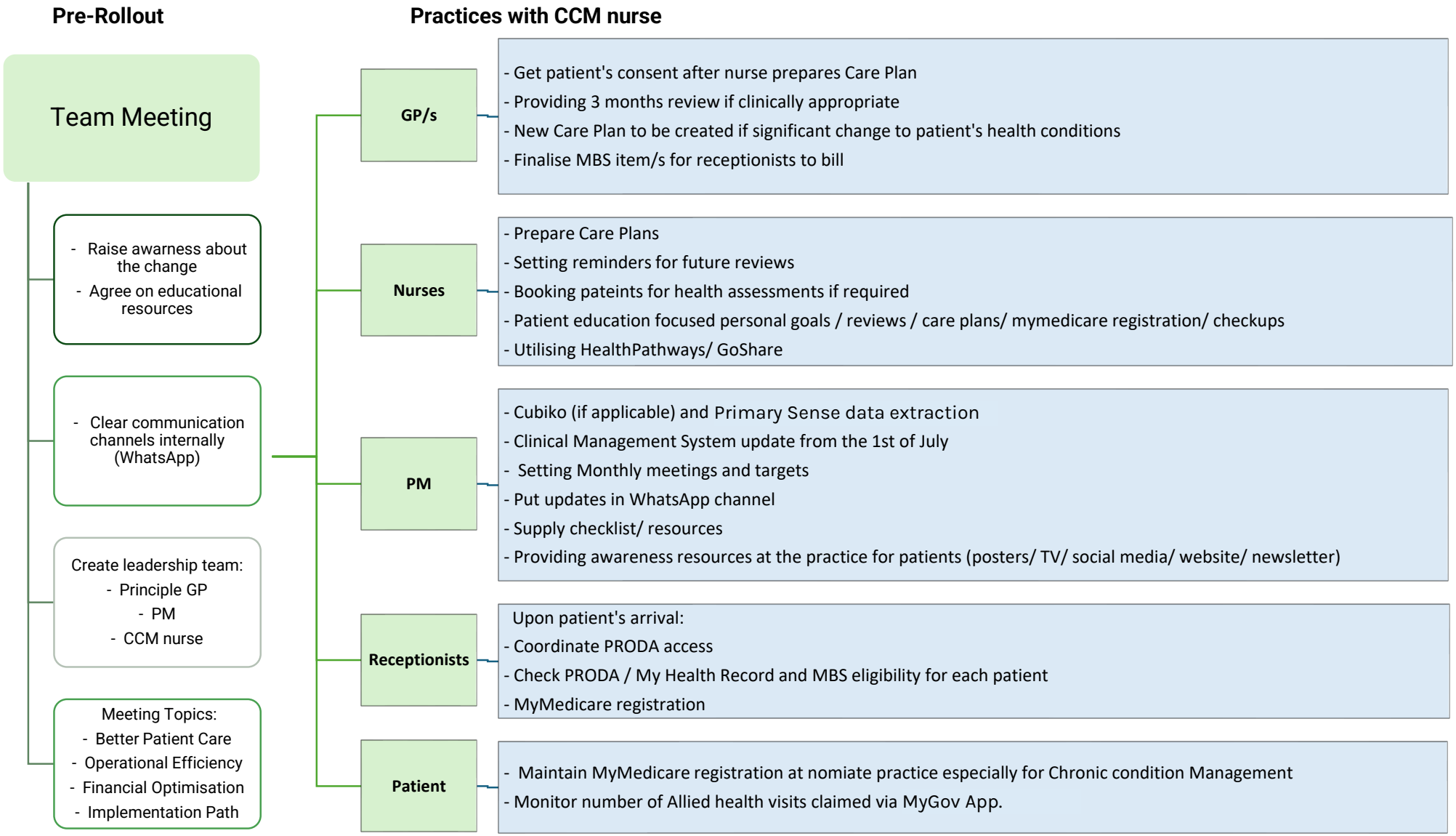
Social supports
Consider social support in home environment, social connectedness, community connections and linkages

4.4 Activity – Roles and Responsibility (Swim Lane workflow)

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



4.5 Activity - Sample workflows



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