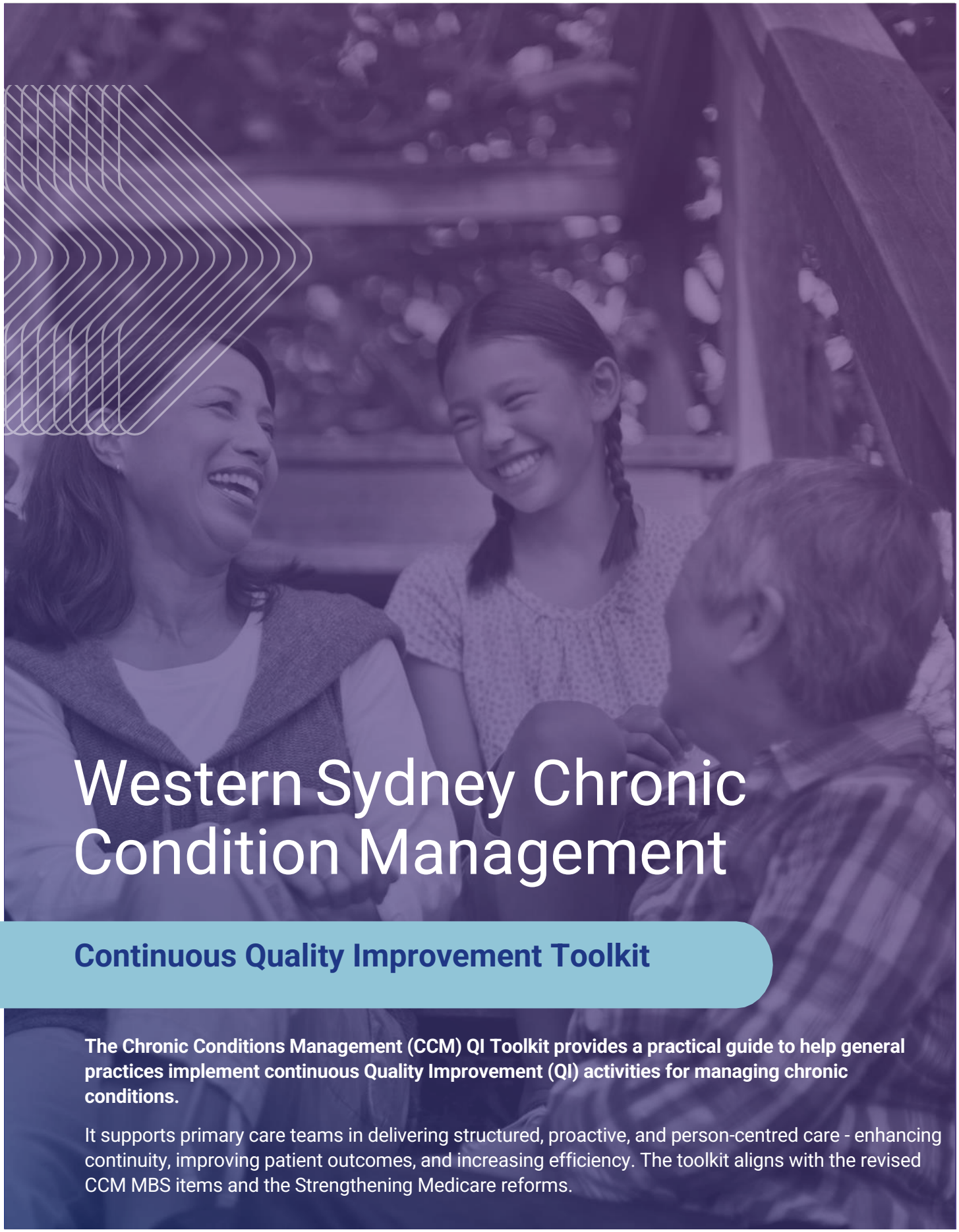

Western Sydney Chronic Condition Management

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 WESTERN SYDNEY An Australian Government Initiative
WentWest

WentWest the Western Sydney Primary Health Network, acknowledges the First Nations peoples of Australia as the Traditional Custodians of the land on which we work and live. We pay our respect to Elders past, present and future and extend that respect to all Aboriginal and Torres Strait Islander peoples within Western Sydney

Acknowledgements

This QI toolkit has been developed by WentWest - Western Sydney PHN and PHN's nationally through the PHN Cooperative, the National Improvement Network Collaborative (NINCo), and the National MyMedicare PHN Implementation Program.

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.

Disclaimer

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Where to get help?

Western Sydney Primary Health Network
E: support@wentwest.com.au
P: (02) 8811 7117

Navigating this toolkit

This toolkit includes practical, flexible activities that are **not sequential**. We recommend starting with **Section One – Practice Readiness** to assess your current state.

Use the **links below** to navigate directly to each activity section.

Click on the section of interest or scroll through in the Workbook in order.

Use the Model for Improvement and Plan-Do-Study-Act (PDSA) cycles. to test changes, drive progress, and embed high-quality chronic condition care aligned with MyMedicare and upcoming MBS reforms.

Introduction

From 1 July 2025, the most significant reforms to chronic disease management in over 20 years

Major changes to the **MBS framework** for chronic disease management in primary care will come into effect. These changes implement the **recommendations** of the MBS Review Taskforce.

Chronic conditions affect 61% of Australians

15.4 million people, including nearly all aged 85+. As demand for connected, multidisciplinary care grows, chronic conditions are driving major pressure on individuals and the health system.

Key changes:

- A **single GP Chronic Condition Management Plan** (GPCCMP) replaces GPMP and TCA.
- All previous items (721, 723, 732, 92024–92028, etc.) will be **ceased and replaced.**
- **Equalised fees** for preparation and review of plans ($156.55 for GPs)

MBS CHANGE ITEM & FEE

Service	GP Item Number	Fee	Replacing
Prepare plan - face-to-face	965	$156.55	721and 723
Prepare plan - video	92029	$156.55	92024 and 92025
Review plan - face-to-face	967	$156.55	732
Review plan - video	92030	$156.55	92028

Other changes:

- Patients with at least **one chronic or terminal condition** will be eligible.
- **Practice Nurses**, Aboriginal and Torres Strait Islander Health Practitioners, and Aboriginal Health Workers can now assist in preparing or reviewing a plan.
- A plan can be **prepared once every 12 months**, and **reviews can occur every 3 months**. A new plan each year is not required—existing plans can be reviewed.
- Domiciliary medication management reviews will require a new-style management plan from 1 July 2027.
- Multidisciplinary care plan items (e.g., for aged care) remain unchanged
- Current plans remain valid during a **2-year transition period** until 30 June 2027.

MyMedicare:

- **Patients registered with MyMedicare** must have plans and reviews provided by their registered practice.
- Unregistered patients can continue to access plans and reviews through their usual GP.

Referring to Allied Health:

- **No need for two collaborating providers to initiate plan** anymore—this requirement has been removed.
- Referral letters will replace existing allied health referral forms.
- Patients must have had a **plan prepared or reviewed within the last 18 months** to access MBS-funded allied health services.

Tip

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

Tools and Enablers

At WentWest, we are investing in the best tools and enablers to help health professionals drive CQI. For user access, contact us **support@wentwest.com.au** or call 8811 7117

Pen CS Suite and QI Dashboard	**Pen Computer System (CS) suite**, including CAT4 and Topbar, enhances clinical data accuracy and decision-making, with WentWest funding access for all Western Sydney practices. Our **Data Dashboard and Reports** support QI through data-driven initiatives, risk stratification, and predictive modelling including **Lumos** – data linkage program.
HealthPathways	Developed by local GPs, specialists, nurses and allied health providers, **Western Sydney HealthPathways** supports health professionals by providing local, relevant information on managing medical conditions and referral options for their patients. ***A login is required.***
GoShare	**GoShare** is a free patient education platform that allows general practices to share tailored and up-to-date resources (including videos and fact sheets) with patients. There are specific **Heart Health Check GoShare bundles** that can help increase health literacy and enhance patient awareness and engagement.
Pharmacist in General Practice	The **Western Sydney Pharmacist in General Practice Program** integrates non-dispensing pharmacists into general practices to provide clinical and educational services as part of a collaborative, patient-centred care team.
Heart Foundation Walking Groups	The **Heart Foundation Walking Groups** are free and are effective in encouraging people to increase their physical activity which can help prevent and manage diabetes, cardiovascular, mental health and their weight. **Join a walking group and make every step matter.**
GP Support Line	GPs have direct access to Local Health District specialist advice and escalation options through the **Rapid Access Stabilisation (RAS) Service** for three streams; **Cardiology, Endocrinology and Respiratory .** Access by calling **GP Support Line** 1300 972 915 (Mon-Fri 9am-7pm).
Remote Monitoring and Screening Devices	Continuous Monitoring: **HeartBug ECG** is a single led ECG allows real-time remote monitoring of patients with suspected arrhythmia. While the **Kardia Mobile** allows quick (30secs), accurate ECG ideal for screening and enabling early detection of Atrial Fibrillation, a key risk factor for stroke.
Primary Mental Health Care	**Primary Mental Health Care** funds psychological services for vulnerable groups, offering up to 9 sessions with a general referral or 12 for those at risk of suicide. GPs must submit a PMHC referral form with patient consent. Alternatively, **Initial Assessment and Referral** (IAR) levels support easy referral pathways.

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.

planning for long-term conditions.
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
- Our MyMedicare Practice Registration Guide
- Our MyMedicare Practice Readiness Checklist

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
- Western Sydney HealthPathways
- RACGP - Chronic disease
- RACGP – Preventive Activities (the Red Book)

Module 2

Patient Registration & Engagement

On completion of this module, you will:

- Enhance communication strategies to boost patient participation in MyMedicare and CCM.
- Develop effective systems for timely care plan review reminder
- Design resources that educate and encourage active involvement in care planning and review

Activity Navigation

Person-centred care is the foundation of both CCM and MyMedicare

At the heart of both **MyMedicare** and Chronic Conditions Management (CCM) is person centred care—healthcare that aligns with each patient's unique values, needs, and life goals. This approach strengthens engagement, supports continuity, and leads to better health outcomes. Core principles include:

1. Dignity
2. Compassion
3. Coordinated
4. Personalised Care
5. Empowerment for Self-Management.

This often begins by asking ***"What matters to you?"*** rather than *"What is the matter with you?"* to better understand and incorporate the patient's life goals into care planning. It fosters greater patient engagement in the care planning process and supports tailored, meaningful care.

Both initiatives promote active patient participation and shared decision-making, moving away from one-size-fits-all models to deliver care that is truly tailored to the individual.

We support practices in delivering person-centred care through programs like our **Patient Centred Medical Home (PCMH)** and **MyMedicare**. These initiatives strengthen connections between patients, their GPs, and care teams while emphasising accessibility, coordination, and quality.

MyMedicare Patient Registration:

1. **Medicare Express Pluss mobile App**
2. **Medicare online - MyGov Account**
3. **Paper registration form**, submitted in person at our practice. You can **pre-fill MyMedicare forms - Refer to Activity**

Tip: Enable **'Auto Accept'** for patient registrations in MyMedicare Preferences via PRODA and pre-fill

Learn more

- **Managing MyMedicare registrations – eLearning**
- Our **MyMedicare Patient Registration Guide**
- Our **MyMedicare One Page Patient Guide**

Patient Resources:

- **MyMedicare - DL Brochure**
- **MyMedicare - Easy Read Brochure**
- **MyMedicare - Poster 1**
- **MyMedicare - Poster 2**
- **MyMedicare - Poster First Nations**
- **MyMedicare - Community Information kit**
- **Introducing MyMedicare Video**
- **Registering in MyMedicare Video**
- **MyMedicare - Social Media Tile**

Module 3

Data-Driven Improvement

On completion of this module, you will:

- Use **CAT4 – Mastering MyMedicare** to drive proactive care. All activities in this module use CAT4 clinical searches and recipes to help identify, segment, and manage cohorts of patients for MyMedicare registration and chronic condition management.
- Apply data-driven strategies to plan, implement, and review quality improvement (QI) activities.

RACGPD Clinical Audit

COMING SOON

WentWest offers a free, CPD-accredited Clinical Audit activity to help practices increase MyMedicare registration for patients with complex health needs. This supports proactive, data-informed care aligned with the 2025 CCM item changes.

CPD Outcomes

Reviewing Performance (RP) — 4 hours

Measuring Outcomes (MO) — 6 hours

Before You Begin

- ☐ Ensure **CAT4 is installed and staff are trained** to use Pen CS tools – use **CAT4 guide** or **videos**
- ☐ **Clean your data** using **CAT4 Data Cleansing** (e.g. archive inactive records, remove duplicates).
- ☐ Standardise coding: ensure diagnoses are **coded, not free text** – use **CAT4 condition mapping**
- ☐ **Filter by doctor**, condition, or age to create a smaller patient list.

Activities Navigation using CAT4

Track & Reflect

- ☐ Download the **audit worksheet or run chart** template
- ☐ Record your baseline and follow-up data
- ☐ Reflect with your team: What worked? What didn't?
- ☐ **Completed QI documentation for CPD**

Module 4

Business & Team Optimisation

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

From 1 July 2025, there will be 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, 92056) 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 i f 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/**

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

Disclaimer: This resource outlines some examples of how General Practice can utilise CCM MBS Items and incorporate participation of other members of the care team, General Practices are advised that this resource does not cover every single scenario or possible structure for scheduling the CCM items. The General Practice or ACCHO model of care, and team structure will further inform the general practice on how the organisation/business may apply Chronic Condition Management. General Practices are encouraged to ensure familiarity and adherence with the MBS.

Appendices

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