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.

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National MyMedicare PHN Implementation Program

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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.

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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 and this icon** 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.

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

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

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**
- **Our MyMedicare Practice Registration Guide**
- **Our MyMedicare Practice Readiness Checklist**

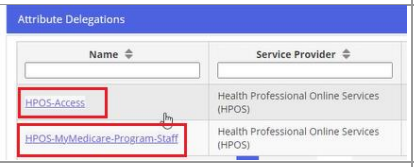
Practice Resources:

- **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)**

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 WentWest Primary Care Facilitator*	
	☐ 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 CAT4 recipes**)	
	☐ 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 (use **GoShare**)	
	☐ 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.	
	☐ Confirm who scans consent forms and completes MyMedicare registration in 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 **CAT4 to to identify eligible patients** (chronic condition + MBS eligibility)	
	☐ 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	

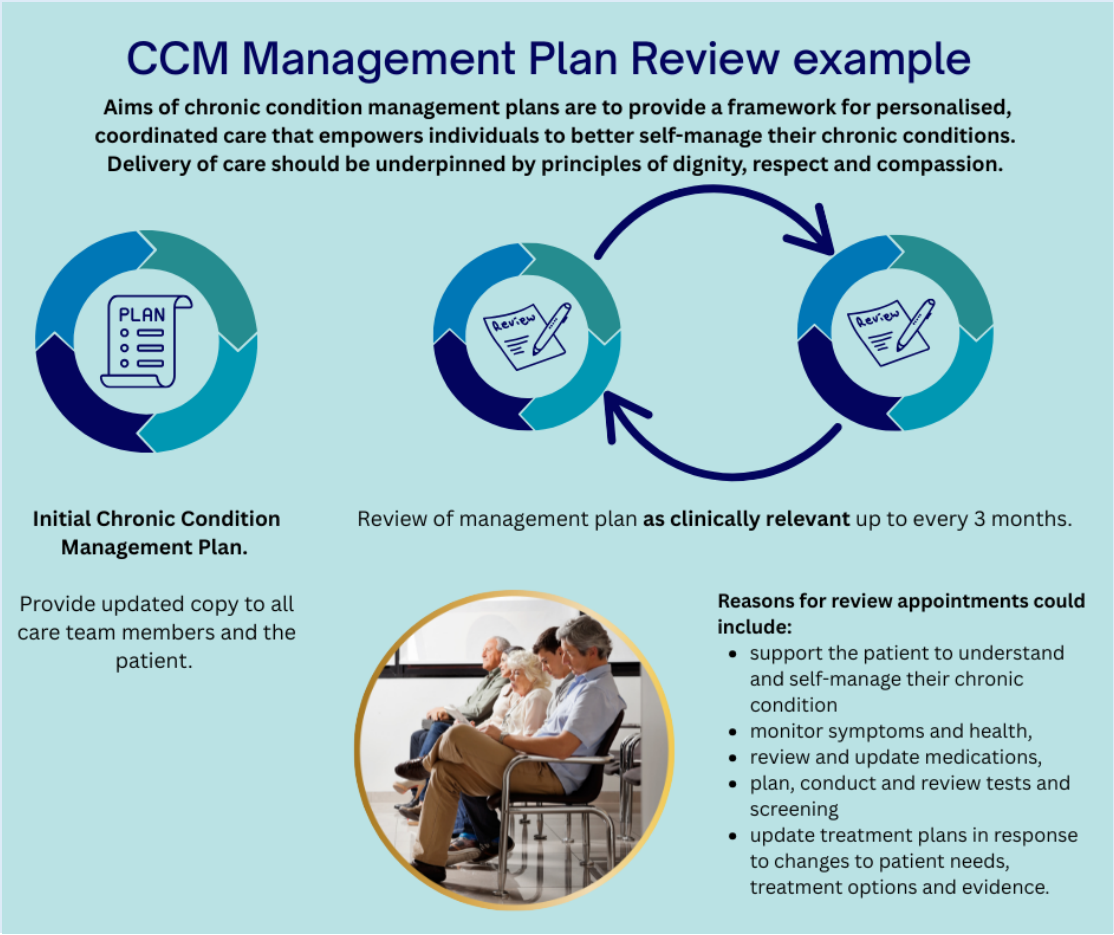
Step 6	ACTIONS	Assigned to
Monitor, Reflect, and Celebrate	☐ Use **QI tools to track** CCM transition activities (e.g., PDSAs, data reviews)	
	☐ Monitor registration targets and plan review timelines	
	☐ Regularly review and update all documentation	
	☐ Review your video telehealth setup for MyMedicare (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.



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.

QI ACTIVITY GOAL EXAMPLE

Develop and apply systems for patient recalls and reminders to enhance MyMedicare registration, Care Planning and the importance of clinically appropriate 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 management plan and aware of coming CCM changes e.g. documented recent conversation with a member of the care team.

Baseline measures

Practice has xxx patients on previous management plans at the start of the activity. The practice has now identified an additional XXX number of patients who should be on a management plan. XX% of patients are registered with MyMedicare.

Data to collect

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

- Percentage rates of MyMedicare patients.
- Percentage attendance for planning or review as scheduled by the patient's clinician/GP.
- Number of patients with a note in their patient record that they have been made aware of the coming CCM changes.

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 or Express Plus Medicare Mobile app**
		• Conversations at appointments including reminder cards, information in clinic rooms.
		• SMS or email campaign
		• **MyMedicare patient forms** offered to patients (note-paper 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**	i.e. CAT4 filters
	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.		• **CAT4 Data Cleansing** • Archiving **BP** | **MD**		Start date - end date	Allocated a usual care provider to patients
	Identify your MyMedicare and CCM patients using CAT4 and document baseline data		• CAT4 **Chronic Conditions**			
	Find eligible patients that are due for management plan/ review		• CAT4 **GPMP/TCA**			Used TopBar prompt
Patient Registration	Ensure **recall and reminder system** is established for MyMedicare and CCM patients		• **BP Reminder** • **MD Recalls**			Upskill staff in **recalls and reminders TrainIT -Course**
	Educate patients on CCM management plan and review benefits		• GoShare **CCM video**			Trained team on **GoShare**
	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**		• **CAT4** | **BP** | **MD**			
	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		• **Western Sydney HealthPathways**			
	Create **patient-centred goals** with more frequent reviews		• CAT4 **Physical activity**			

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.*		RP 30mins

	• *MyMedicare General Practice Communication Toolkit here* • *CCM MBS item changes – **Overview** here* • *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*	
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*	

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

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 Plus 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**

2.1 Activity – Reminders, Registration and Flagging

This activity helps practices implement or enhance reminder and recall systems to improve MyMedicare registration, support care planning, and ensure timely reviews for patients with chronic conditions. By leveraging your clinical software, you can:

- Proactively identify and flag eligible patients
- Pre-fill MyMedicare registration forms (RTF) for individual patients or bulk print them using mail merge
- Automate communication and reminders
- Improve data accuracy and patient engagement

This enables smoother registration, better continuity of care, and future-ready MBS claiming.

Patients can then register using these pre-filled paper forms or via the Medicare Online Account or Express Plus Medicare Mobile app

The following steps and screenshots show how to register and flag patients in Best Practice, Medical Director, and My Health Record.

Software-Based Instructions

Best Practice (BP)

BP Spectra will compass all CCM changes including database searches, printable **guides** and **desktop foldout** resources

- Use **MyMedicare Awareness and BP Comms** to reach eligible patients
- Use **BP database queries to identify eligible patients**
- Tools:
  - **Reminder**
  - **Actions**
  - **Mail merge**
  - **SMS reminders**

📘 **WentWest's Best Practice Guide for MyMedicare**
🌐 **BP MyMedicare** | **www.bpsoftware.net**
📞 **1300 40 1111**

Medical Director (MD) and Pracsoft

- Use **Telstra Health Smart Visual Dashboards** to identify eligible patients, Track MyMedicare registrations, Send SMS reminders
- Tools:
  - **Reminders**
  - **Actions**
  - **Mail merge**
  - **SMS reminders**
- Resources

📘 **WentWest's Medical Director Guide for MyMedicare**
🌐 **MD MyMedicare** | **www.medicaldirector.com**
📞 **1300300161**

Cubiko (for BP/MD users)

- **GPCCMP home**
  - **Cubiko Insights** - GPCCMP metrics and forecasting dashboard
  - **Cubiko Insights**: CCM Preparation: Actionable metrics My Dashboard
- **Resource pack** including staff room poster, patient handout, flyer and printouts
- **Identify and flag MyMedicare eligible patients**
- **Export/import CSV lists** for targeted outreach

📘 **WentWest's Cubiko Guide for MyMedicare**
🌐 **Cubiko Knowledgebase**
📞 1300 CUBIKO

Other Reminder Systems

The following platforms can also be used independently or in conjunction with your clinical software to manage patient recalls and reminders:

- **Pracsoft**
- **Hotdoc**
- **Healthengine**
- **AutoMed**

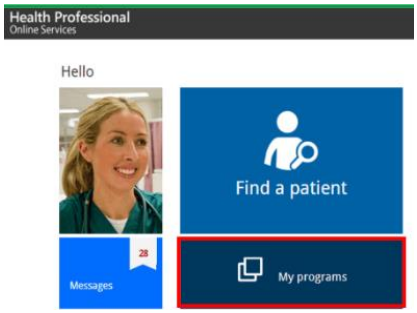
Note: WentWest does not provide software licensing for these systems.

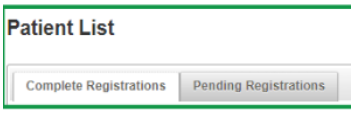
2.1.1 Management registration via HPOS

To support your team, access **the Services Australia MyMedicare eLearning modules** for **MyMedicare overview** and **Managing patient registration**

Accessing the Patient List in HPOS >MyMedicare program

1. Log in to **PRODA** to use HPOS → Select the organisation to act on behalf of.
2. **My Programs → MyMedicare**
3. Go to **Patient List**

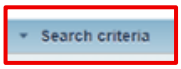




Tip: If "MyMedicare" doesn't appear, your PRODA access may need updating.

Viewing Withdrawn or De-registered Patients

4. In the Patient List, use the **Search Criteria** filters



5. Tick **"Withdrawn registrations"** to include de-registered patients.
6. Look under the **"Date Withdrawn"** column to see when deregistration occurred.

Date Registered	Date Withdrawn	Initiated By
10/10/2023	19/05/2025	Patient
16/10/2023	14/05/2025	Practice

Exporting Patient Records

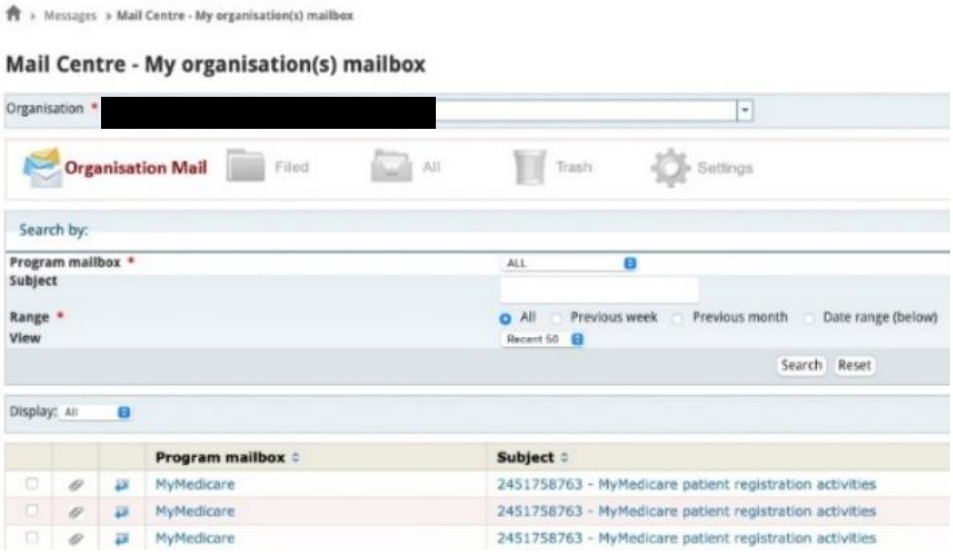
7. Click **Export Complete Registrations List** to download both Complete and Pending lists). Use this list to track deregistered patients and take follow-up action

MyMedicare patient registation activities					
Run Date/Time: 04/06/2025 04:03:03					
Notes:					
This list may contain registrations waiting to be accepted or declined by the practice.					
Activity	Activity Date/Time	Decline Reason	Date Cancelled	Date Withdrawn	Withdrawal Reason
Complete Registration Created	03/06/2025 14:21:56				
Complete Registration Created	03/06/2025 14:25:13				
Preferred GP Amended	03/06/2025 14:26:21				
Complete Registration Created	03/06/2025 14:29:20				
Withdrawal Date Added	03/06/2025 14:52:51			02/06/2025	Another practice registered patient

Managing MyMedicare via HPOS Mail Centre

1. Log in to **PRODA** to use HPOS → Select the organisation to act on behalf of.
2. Go to **Messages** → **My organisation(s) mailbox**.
3. Select **Settings** → Choose your **email** and **notification frequency** (immediate, daily, weekly)
4. Click **Submit**.

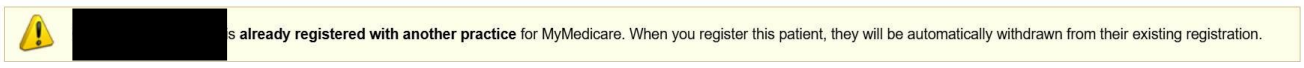
Here's an example of MyMedicare Patient registration activities



Individual patient

1. Log in to **PRODA** to use HPOS → Select the organisation to act on behalf of → **My Programs** → **MyMedicare**
2. Go to **Register a patient** → Find a patient
3. **Enter details**: Medicare/DVA CARD number, IRN, First name, DOB → tick declaration → click **Find**
4. **Select patient** → **Register for MyMedicare**
5. Choose: **Practice** (Organisation site) → **Preferred GP**
6. **Confirm eligibility** (auto or select reason)
7. **Review details** → tick declaration → click **Confirm**
8. For pending registration: choose "Pending" instead of "Complete" on step 4.

If the patient is registered with another practice, this message will appear:



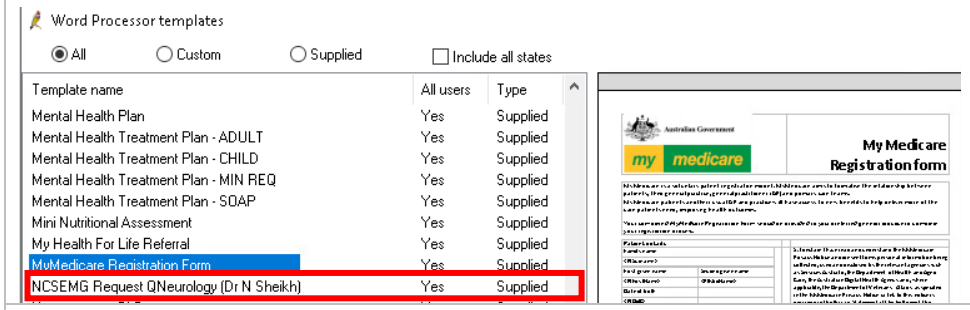
2.1.2 Best Practice – CCM, MyMedicare Registration and flagging

For the latest updates, visit BP Premier Spectra including MyMedicare Medicare Web services (enrolment management and registration check) new templates (GPCCMP and CCMP AHP referral), appointment types, SQL queries and Co-billing logic.

MyMedicare Registration Form via Letter writer

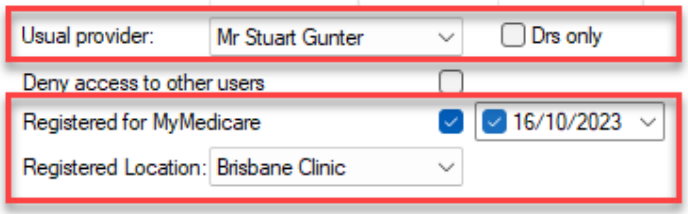
Letter writer (RTF format) will **auto-populate with patient details** ready for patient to provide sign consent.

File→ New Letter (F4) → Templates→ Use Template→ Open



Individual Patient Registration

File → Open Patient → View → Patient/F2 → View details → Complete the fields listed below → Save

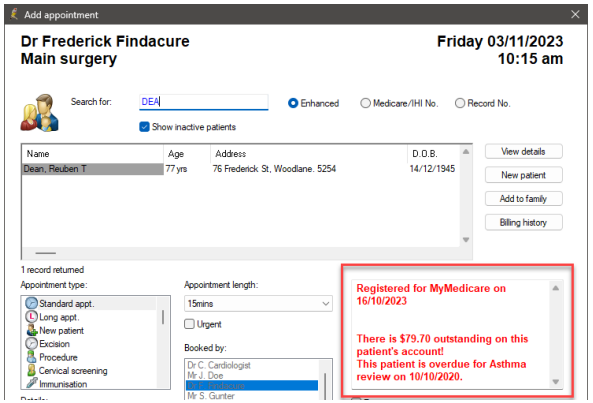


Flagging MyMedicare registered status

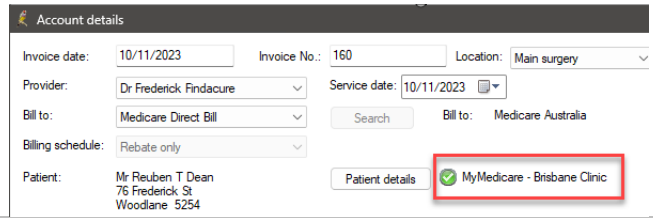
MyMedicare Registered status will be displayed on:

Patient Record

Appointment book



Invoices



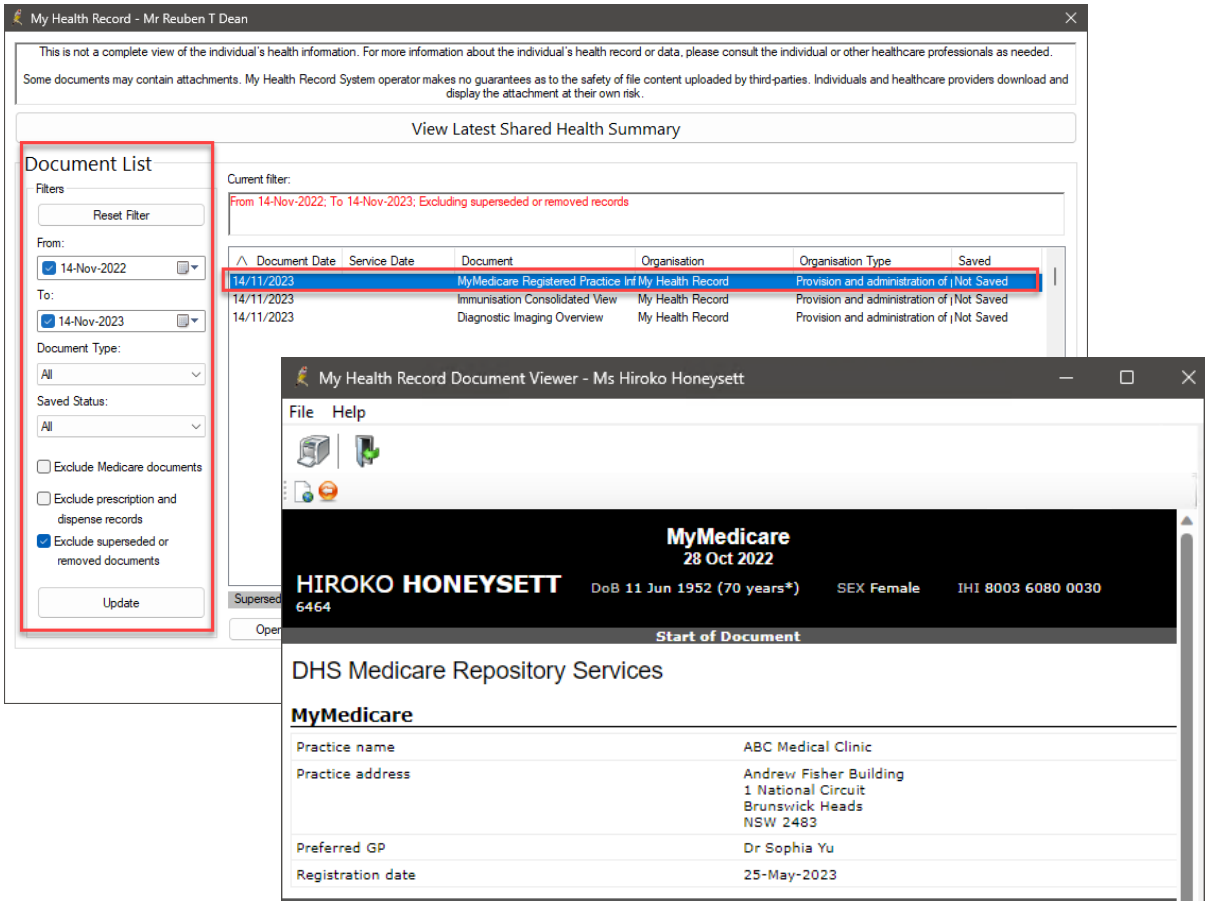
CALL TO ACTION

Bulk import option of MyMedicare: Download exported registration list from HPOS for patient registration status and import list using **Bp Premier Reporting Tool** for full details include HPOS screenshots – refer to **WentWest's Best Practice Guide for MyMedicare**

2.1.3 Best Practice - My Health Record & MyMedicare Registration

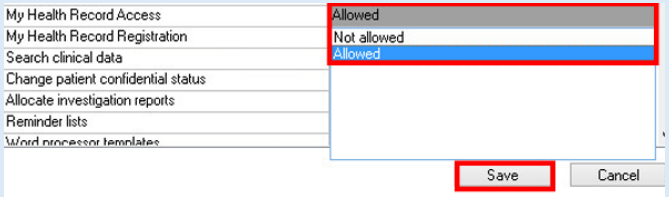
Retrieve MyMedicare Documents from My Health Record. MyMedicare information is sourced from Medicare systems operated by Services Australia and includes the patient's Registration date, Practice Name, Practice Address, and preferred GP name, if supplied.

File → Open Patient, View→ Patient/F2→ **My Health Record → View Document List → Filters →** untick the **Exclude Medicare documents** and **Exclude prescription and dispense records →** **Update →** select **MyMedicare Registered Practice information** document → **Open**



To access My Health Record, your staff

- must have an **HPI-I** (identifies individual healthcare providers) To obtained via **AHPRA** account or by calling 1300 419 495, while non-AHPRA staff can apply through **HPOS**.
- **Set User permissions**: Best Practice main screen > Setup > Users > select employee > Edit > Set Permissions > scroll to My Health Record Access > Select 'Allowed' > Save.



Please note the **My Health Record participation obligations** and **Security and Access policies – Rule 42 guidance.**

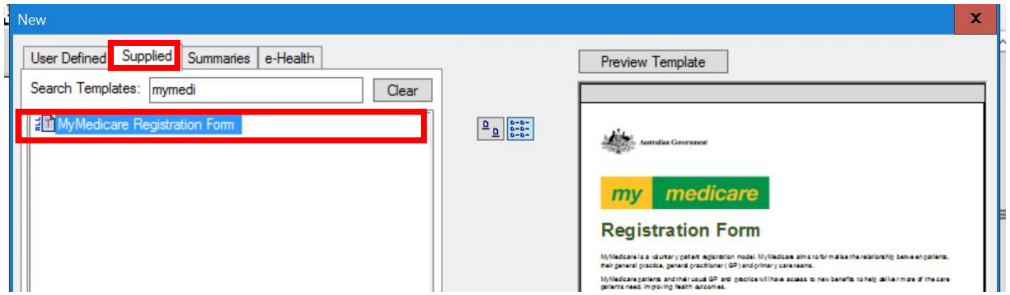
Save a Document to a Patient Record
Please note patent preference to save this document - **See Understanding confidentiality and patient notes for more information.**

2.1.4 Medical Director – MyMedicare Registration and flagging

MyMedicare Registration Form via Letter writer

Letter writer (RTF format) will **auto-populate with patient details** ready for patient to provide sign consent.

Patient File → Tools → Letter Writer (F8) or  **→ File → New → Ok**



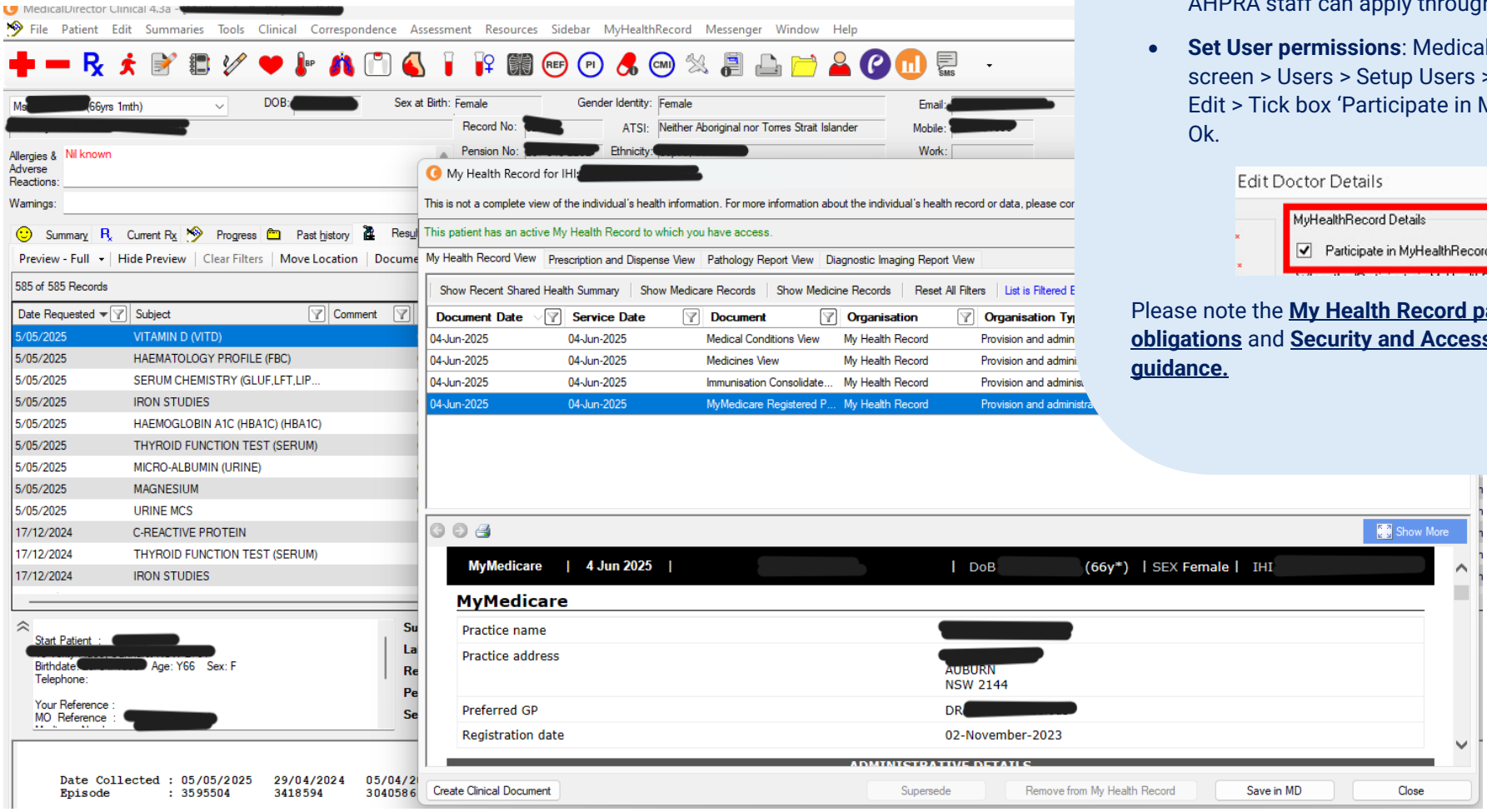
Individual Patient Registration

File → Open Patient → View details →tick "This patient is registered with this Practice for MyMedicare" → select Preferred GP = "Regular Practitioner" → Save

2.1.5 Medical Director - My Health Record & MyMedicare Registration

Retrieve MyMedicare Documents from My Health Record. MyMedicare information is sourced from Medicare systems operated by Services Australia and includes the patient's Registration date, Practice Name, Practice Address, and preferred GP name, if supplied

Patient File→ My Health Record (or view document list)



To access My Health Record, your staff

- must have an **HPI-I** (identifies individual healthcare providers) To obtained via **AHPRA** account or by calling 1300 419 495, while non-AHPRA staff can apply through **HPOS**.
- **Set User permissions**: Medical Director main screen > Users > Setup Users > select employee > Edit > Tick box 'Participate in MyHealthRecord' > Ok.

Please note the **My Health Record participation obligations** and **Security and Access policies – Rule 42 guidance.**

Save a Document to a Patient Record

Please note patent preference to save this document - **See Understanding confidentiality and patient notes for more information.**

2.2 Activity – Scripts: phone, SMS, email, and website

Please tailor **scripts** for **phone, SMS, email, and website** for staff to use when communicating with patients about **Chronic Condition Management Plans** and **MyMedicare**.

Phone Script
(Reception or Nurse Call)

Hi, this is [Your Name] from [Practice Name]. I'm just checking in about your ongoing care.

If you have a health condition that lasts six months or more, you may be eligible for a Care Plan. This supports your health with a clear plan, plus up to 5 subsidised visits per year to allied health providers like a physio or dietitian.

We also recommend registering for MyMedicare, which helps us provide more coordinated care.

Would you like to book a longer appointment to get started or get more info?

SMS Script

Hi [First Name], you may be eligible for a Care Plan and MyMedicare registration with your GP at [Practice Name].

This can support your ongoing care and give access to subsidised allied health visits.

Call [Phone] or book online: [Website]

Keep it clear, professional, and actionable.

Email Script

Subject: **Care Plan & MyMedicare – Supporting Your Health**

Hi [First Name],
If you have a long-term health condition, you may benefit from a Care Plan at [Practice Name]. It helps you and your GP plan and manage your care, and may include up to 5 subsidised allied health visits per year.
We also recommend registering with MyMedicare to make sure your care is continuous and well-coordinated.
A longer appointment is needed to set up your plan.
You'll check in with your GP every 3–6 months.
Reply to this email, call us on [Phone], or book online at [Website]

Website Text
(Info Page or Pop-up)

Do you have a long-term health condition?

We can help you manage it with a Care Plan at [Practice Name]. This includes:

- Your health goals
- How we'll support you
- Up to 5 Medicare-subsidised visits to allied health providers

We also recommend registering for MyMedicare, a free program that links you to us as your regular practice — for more coordinated care.
Longer appointments are needed to set up your plan
You'll check in with your GP every 3–6 months
Ask us today, or [Book Online Now]

CALL TO ACTION

Do a PDSA - Reducing Missed Appointments for Care Plan reviews

2.3 Activity – GoShare Patient Engagement Platform

GoShare is a free* patient education platform enabling health professionals to send tailored, trusted resources—such as videos and fact sheets—via email or SMS to help patients manage their health, improve **health literacy, and boost engagement**.

NEW! Use the ***What is a Chronic Condition Management Plan?* low-literacy video** to help explain recent CCM changes and the importance of regular reviews to your patients. You can also use the ***MyMedicare* bundle –** an all-in-one resource to increase awareness about the benefits of registering with your practice.

To get started or request access, please contact our team **support@wentwest.com.au**

**Free access provided through WentWest for general practices in* Western Sydney.

Quick Instructions

For Best Practice (BP) Users
Using GoShare BP PSI Integration

1. **Install & Access:**
   - Ensure GoShare PSI is installed and activated in Best Practice. **GoShare PSI download instructions**
   - Log into GoShare PSI.

2. **Create Campaign**

Choose eligible patients by selecting a pre-built query from the GoShare PSI library.
   - Diagnosed with chronic condition
   - Not registered for MyMedicare

3. **Send Bundle**
   - Choose SMS or email delivery.
   - Review and send to patients (you can stagger the sending in batches).

All Users – Web-Based
Using GoShare Portal

1. **Log In: https://goshare.realtimehealth.com**

2. **Build a Bundle**
   - Find MyMedicare or CCM resources (videos, fact sheets).
   - Click “Add to bundle”, then ★ (star icon) to save.

3. **Send to Patients**
   - Click “Send bundle to list”.
   - Download CSV template.
   - Populate with patient details (Name, Phone, Email).
   - Upload, review, and send.
   - Direct Sends (Optional).
   - Click “Send bundle” → “New Recipient” → enter details → “Done”.

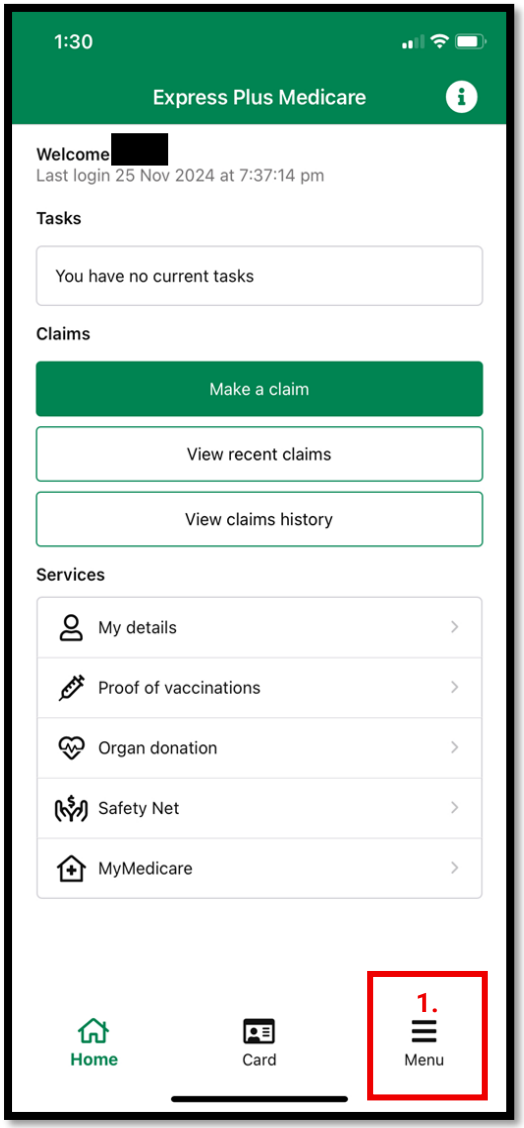
For Medical Director /Zedmed Users
Using CAT4 & GoShare Plus

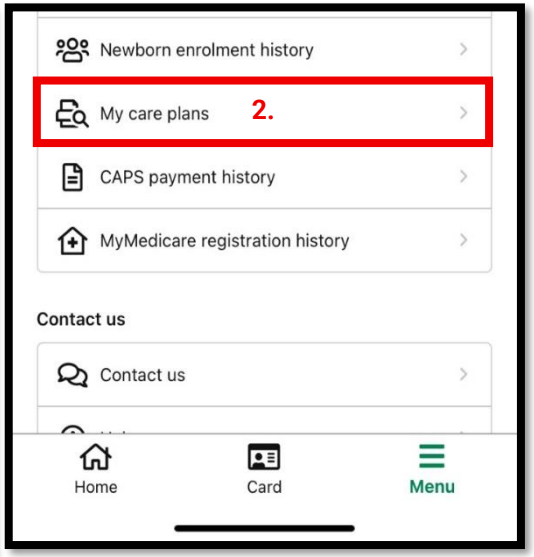
1. **Extract Patient Lis**
   - Open CAT4, apply filters:
     i. ≥2 visits in 24 months
     ii. Chronic conditions
     iii. Not registered for MyMedicare
   - Export selected patient list as CSV file.

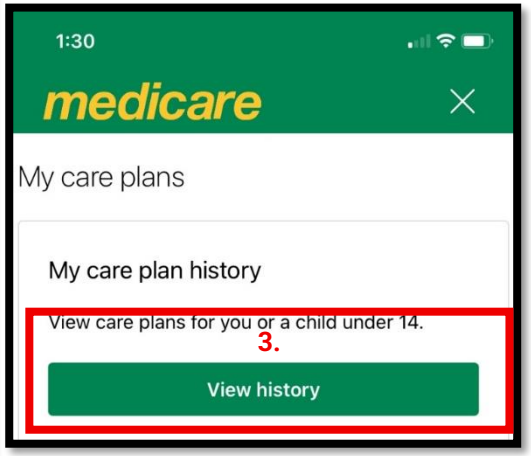
2. **Upload to GoShare Plus**
   - Log into GoShare Plus.
   - Select MyMedicare or CCM bundle.
   - Upload CSV via “Send bundle to list”.
   - Match fields and send via SMS or email.
   - Follow Up.

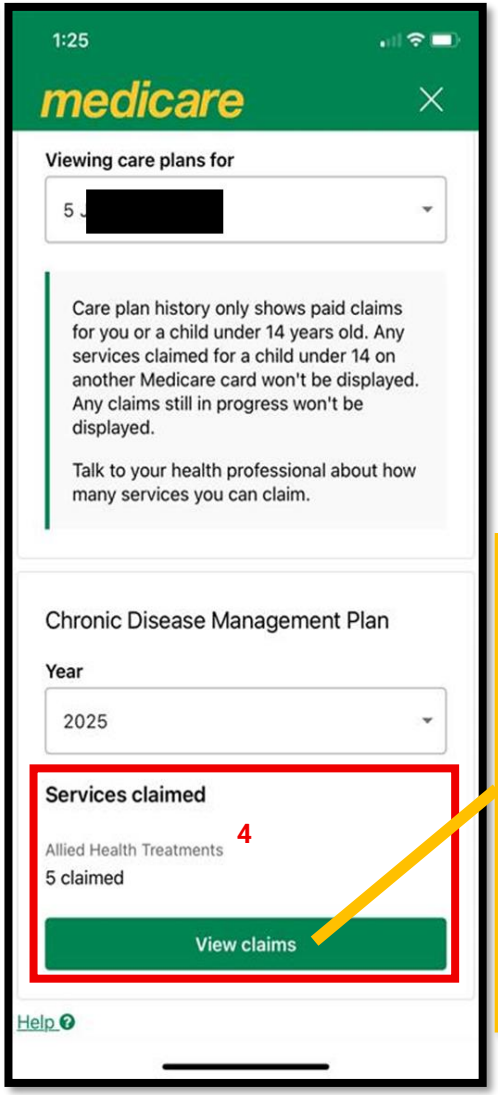
2.4 Activity – Check the number of allied health service

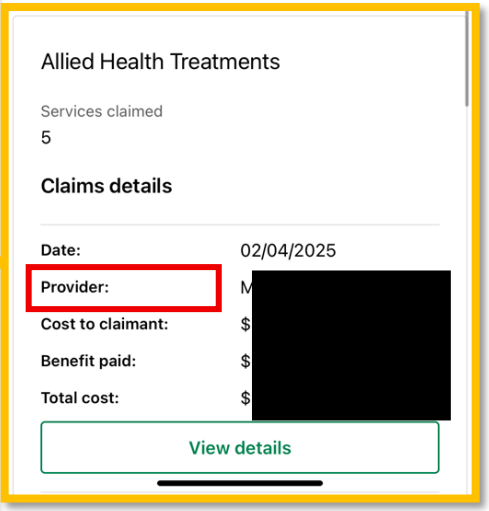
1. Download and sign into **Medicare Express Plus App** or **Medicare via MyGov**
2. Go to **'Menu'** and select **'My Care Plans'**
3. Select 'View history'. If multiple patients appear, choose the relevant name
4. View **Service claimed,** including the number of Allied health visits claimed and provider details











Scan the QR code to download and use the Medicare Express Plus App.

***Note**: you can also download history (PDF) and when someone has accessed the care plans.*

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.

RACGP 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

3.1 Activity – MyMedicare patients
3.2 Activity – Patients not registered with MyMedicare
3.3 Activity – All CCM Patients due for a care plan and reviews
3.4 Activity – Patients with a chronic condition eligible for care plan or review
3.5 Activity – Patients with risk of hospitalisation eligible for care plan or review
3.6 Activity – Filter by assign provider
3.7 Activity – Create a prompt to display in Topbar

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**

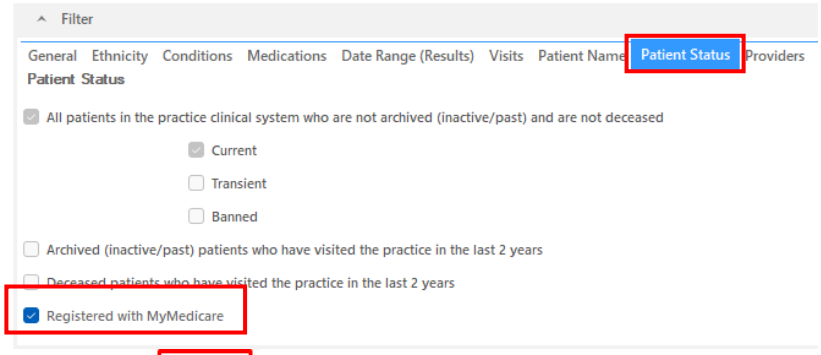
3.1 Activity – MyMedicare patients

🎯 **Activity Goal:** Identify patients who are MyMedicare registered at your practice.

➢ **Starting point: Log into Pen CS CAT4** → Show Extracts → load latest data extract → Hide Extract

➢ **In Filter Panel**

1. Under '**Patient Status**' tab → tick '**Registered with MyMedicare**'



2. Recalculate 

3. View Population 

4. Optional: Select Export →  XLS File → Save (e.g. Create a folder C:/ClinicalAudit/CAT Patient FollowUp)

5. Optional: **filter patient list by provider**

6. Optional: **create a Topbar prompt**

3.2 Activity – Patients not registered with MyMedicare

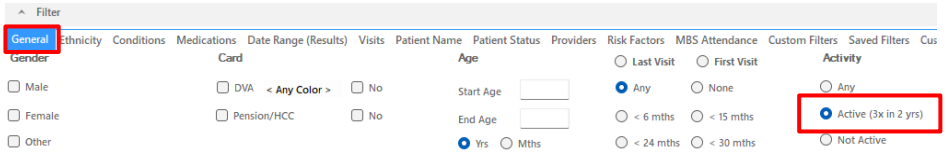
🎯 **Activity Goal:** Identify patients who may be eligible for **Voluntary Patient Registration** at a general practice, based on having had at least two face-to-face visits in the past two years or who are active based on RACGP definition of 3 visits in the past 2 years. Optionally, exclude patients without a Medicare card.

➢ **Starting point: Log into Pen CS CAT4** → Show Extracts → load latest data extract → Hide Extract

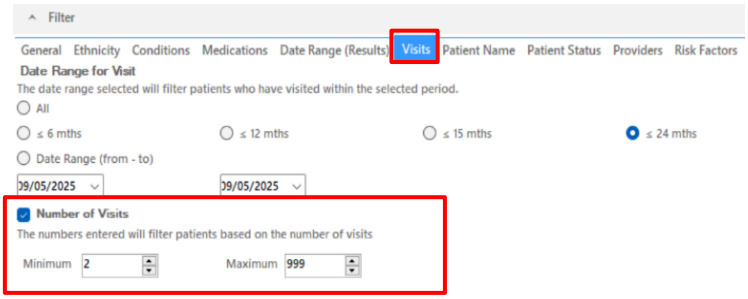
➢ **In Filter Panel**

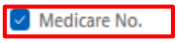
1. Choose from the following **two options** to identify patients by active status or number of visits

Optional 1: Under '**General**' tab → Activity → Select 'Active (3 x in 2 yrs)'

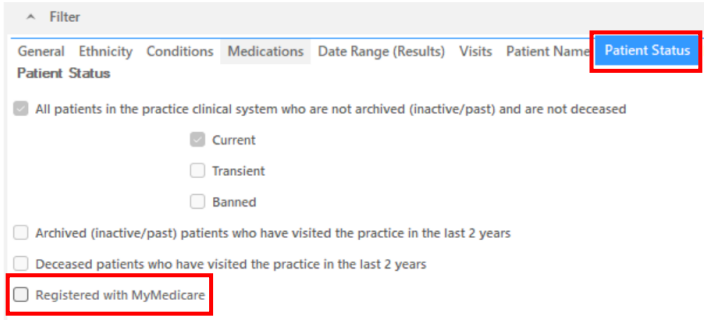


Optional 2: Under '**Visits**' tab → Select "≤24 mths" → "Number of Visits" box and enter "minimum: 2 and maximum: 999"



2. Optional: Under '**General**' tab select '**Medicare No.**' 

3. Under 'Patient Status' tab → untick **'Registered with MyMedicare'**



4. Recalculate 

5. View Population 

6. Optional: Select Export →  XLS File → Save (e.g. Create a folder C:/ClinicalAudit/CAT Patient FollowUp)

7. Optional: **filter patient list by provider**

8. Optional: **create a Topbar prompt**

Do a PDSA – Identifying Active Patients & Linking to MyMedicare Program

3.3 Activity – All CCM Patients due for a care plan and reviews

🎯 **Activity Goal:** Enhance care plan delivery for MyMedicare-enrolled patients managing chronic conditions.

➢ **Starting point:** Log into Pen CS **CAT4** → Show Extracts → load latest data extract → Hide Extract

➢ **In Filter Panel**

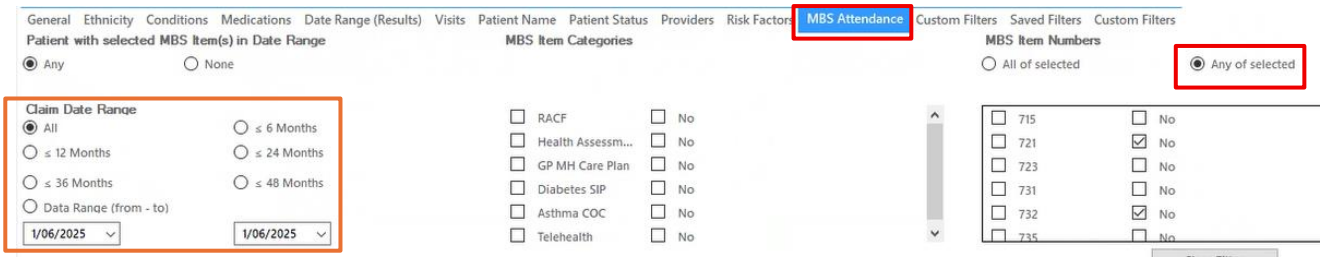
Do a **PDSA – CCM and MyMedicare**

1. **MyMedicare patient filter (Choose either MyMedicare enrolled or Not (Yet) enrolled):**
   - **A.** Under '**Patient Status**' tab → tick '**Registered with MyMedicare**'
   - **B.** Under '**Patient Status**' tab → untick '**Not Registered with MyMedicare**, and then follow the steps
     - **Optional 1**: Under '**General**' tab → Activity → Select 'Active (3 x in 2 yrs)'
     - **Optional 2:** Under '**Visits**' tab → Select "≤24 mths" → "Number of Visits" box and enter "minimum: 2 and maximum: 999"'

2. **CCM MBS filter (restricts cohort to those who have not had a Care Plan / Review in last "x" period):**

   Under **'MBS Attendance'** → select **'Any of selected'** → select **'No' to 721, 723 or 732 (and 965/967 after 1 July 2025)**

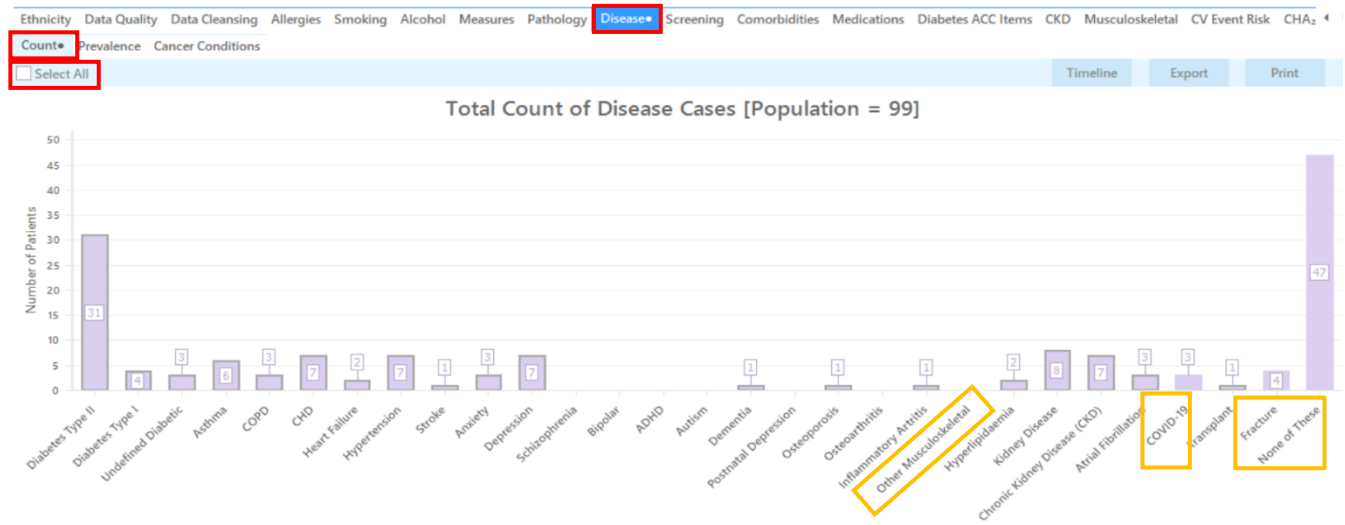
   Optional: Under **'MBS Attendance'** → select 'Claim Date Range' for example:
   - '≤12months' (care plans not billed in the past 12 months)
   - '≤6 Months' (care plans reviews not billed in the past 6 months)
   - Date Range (from – to): 11/3/25 – 11/6/25 (care plan reviews not billed in the past 3month)



3. **Recalculate**

➢ **In Report Panel**

4. Under '**Disease**' tab → '**Select all**' → then **exclude** the following conditions: Other Musculoskeletal; Covid-19; Fracture; None of these.



5. Optional: Select Export → XLS File → Save (e.g. Create a folder C:/ClinicalAudit/CAT Patient FollowUp)
6. Optional: reduce patients list by filtering by: **Condition** , **Risk of hospitalisation** or **Assigned provider**

3.4 Activity – Patients with a chronic condition eligible for care plan or review

🎯 **Activity Goal:** Increase care plan completion for MyMedicare-registered patients with a specific condition. *As there are a range of conditions that could fall under this group, here are examples to help identify MyMedicare eligible patients within the **diabetes** cohort.*

➢ **Starting point: Log** into Pen CS **CAT4** → Show Extracts → load latest data extract → Hide Extract

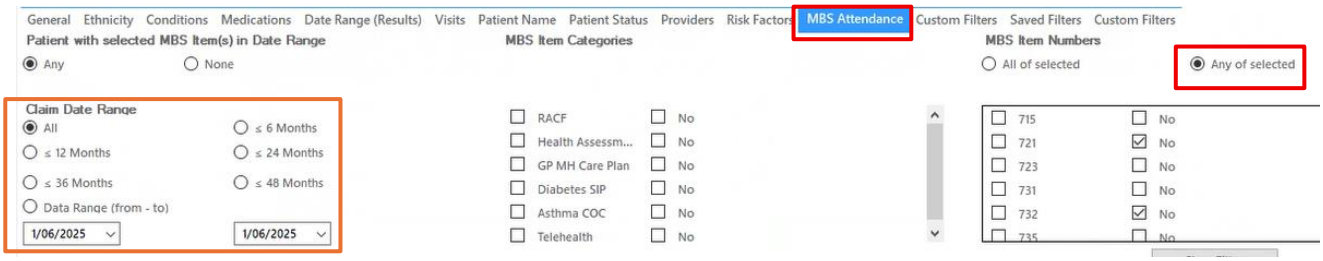
➢ **In Filter Panel**

1. **MyMedicare patient filter (Choose either MyMedicare enrolled or Not (Yet) enrolled):**
   - **A.** Under '**Patient Status**' tab → tick '**Registered with MyMedicare**'
   - **B.** Under '**Patient Status**' tab → untick '**Not Registered with MyMedicare**, and then follow the steps
     - **Optional 1**: Under '**General**' tab → Activity → Select 'Active (3 x in 2 yrs)'
     - **Optional 2:** Under '**Visits**' tab → Select "≤24 mths" → "Number of Visits" box and enter "minimum: 2 and maximum: 999"'

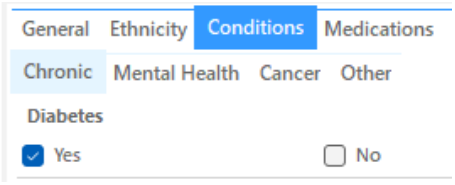
2. **CCM MBS filter (restricts cohort to those who have not had a Care Plan / Review in last "x" period):**

   Under **'MBS Attendance'** → select **'Any of selected'** → select **'No' to 721, 723 or 732 (and 965/967 after 1 July 2025)**

   Optional: Under **'MBS Attendance'** → select 'Claim Date Range' for example:
   - '≤12months' (care plans not billed in the past 12 months)
   - '≤6 Months' (care plans reviews not billed in the past 6 months)
   - Date Range (from – to): 11/3/25 – 11/6/25 (care plan reviews not billed in the past 3month)



3. Under **'Conditions'** → select 'Diabetes - Yes'



Do a PDSA – CCM and MyMedicare

4. Recalculate

5. View Population

6. Optional: Select Export → XLS File → Save (e.g. Create a folder C:/ClinicalAudit/CAT Patient FollowUp)

7. Optional: **filter patient list by provider**

8. Optional: **create a Topbar prompt**

3.5 Activity – Patients with risk of hospitalisation eligible for care plan or review

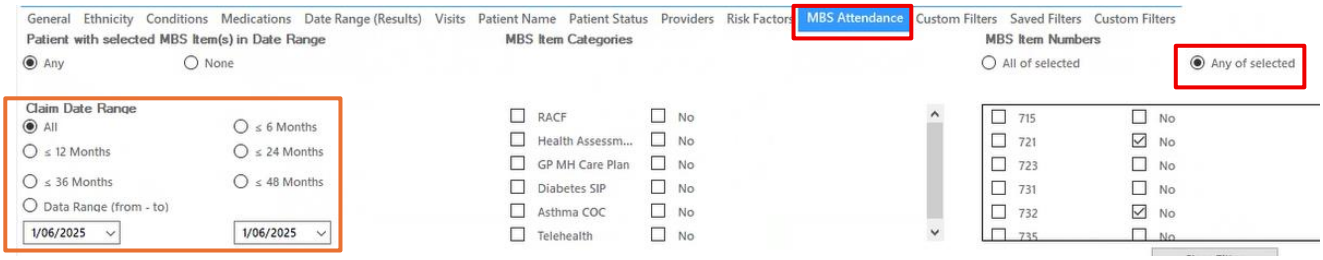
🎯 **Activity Goal:** Increase care plan completion for MyMedicare-registered patients with high risk of hospitalisation within the next 12 months.

The CAT – Risk of Hospitalisation report uses the **CSIRO's predictive risk stratification** algorithm to identify patients in general practice at high risk of hospitalisation within the next 12 months, categorising them into six risk levels based on factors such as conditions, medications, pathology, and demographics.

➢ **In Filter Panel**

1. **MyMedicare patient filter (Choose either MyMedicare enrolled or Not (Yet) enrolled):**
   - **A.** Under '**Patient Status**' tab → tick '**Registered with MyMedicare**'
   - **B.** Under '**Patient Status**' tab → untick '**Not Registered with MyMedicare**, and then follow the steps
     - **Optional 1**: Under '**General**' tab → Activity → Select 'Active (3 x in 2 yrs)'
     - **Optional 2:** Under '**Visits**' tab → Select "≤24 mths" → "Number of Visits" box and enter "minimum: 2 and maximum: 999"'

2. **CCM MBS filter (restricts cohort to those who have not had a Care Plan / Review in last "x" period):**
   Under **'MBS Attendance'** → select **'Any of selected'** → select **'No' to 721, 723 or 732 (and 965/967 after 1 July 2025)**
   Optional: Under **'MBS Attendance'** → select 'Claim Date Range' for example:
   - '≤12months' (care plans not billed in the past 12 months)
   - '≤6 Months' (care plans reviews not billed in the past 6 months)
   - Date Range (from – to): 11/3/25 – 11/6/25 (care plan reviews not billed in the past 3month)

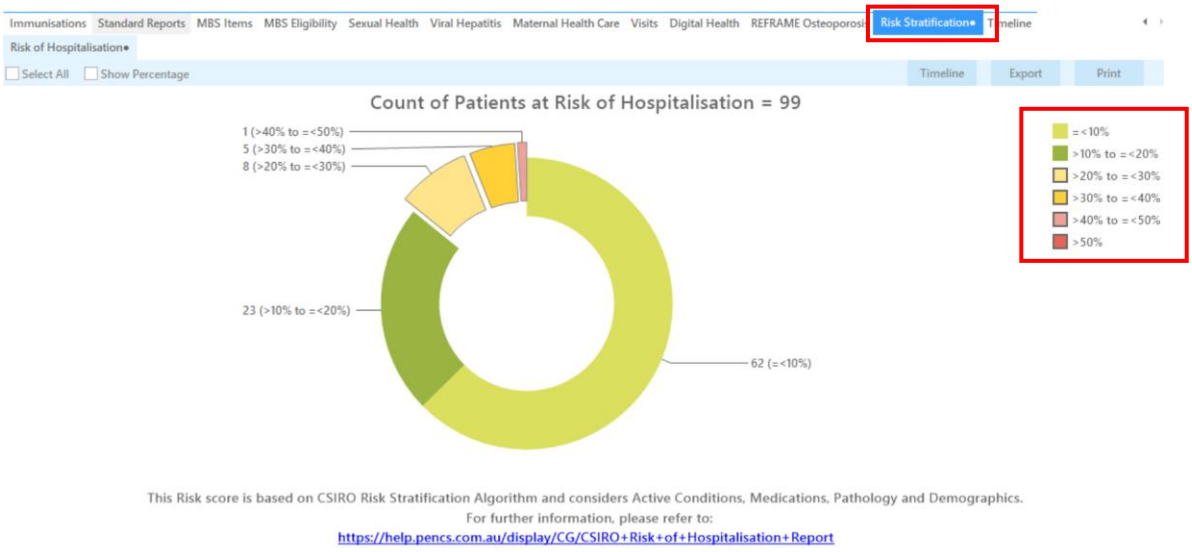


3. Recalculate

➢ **In Report Panel**

4. Click the **"Risk Stratification"** tab. 

5. The report shows patients grouped into six risk levels.
6. To view patients in a specific risk group, click percentage risk percentage (i.e. >40%) or the pie chart.



7. **Optional**: Select Export →  XLS File → Save *(e.g. Create a folder C:/ClinicalAudit/CAT Patient FollowUp)*

3.6 Activity – Filter by assign provider

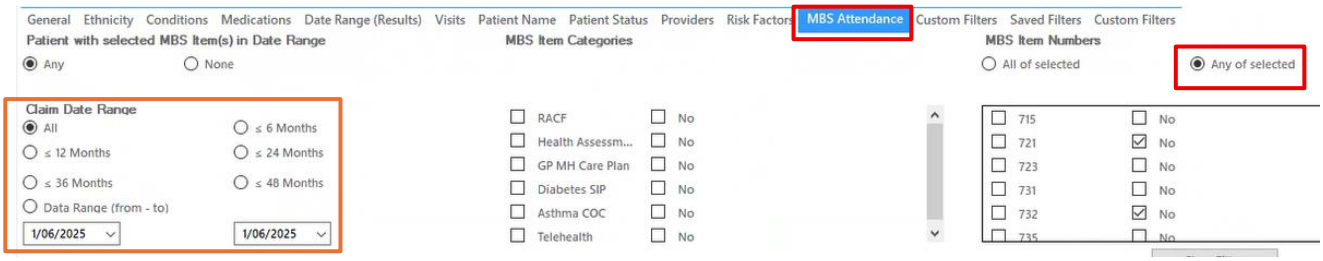
🎯 **Activity Goal:** Identify the provider the patient has seen most often in the past 18 months, that they were not billed for MyMedicare, care plan or have a specific condition

➢ **Starting point: Log into Pen CS CAT4** → Show Extracts → load latest data extract → Hide Extract

➢ **In Filter Panel**

1. **MyMedicare patient filter (Choose either MyMedicare enrolled or Not (Yet) enrolled):**
   - **C.** Under '**Patient Status**' tab → tick '**Registered with MyMedicare**'
   - **D.** Under '**Patient Status**' tab → untick '**Not Registered with MyMedicare**, and then follow the steps
     - **Optional 1**: Under '**General**' tab → Activity → Select 'Active (3 x in 2 yrs)'
     - **Optional 2:** Under '**Visits**' tab → Select "≤24 mths" → "Number of Visits" box and enter "minimum: 2 and maximum: 999"'

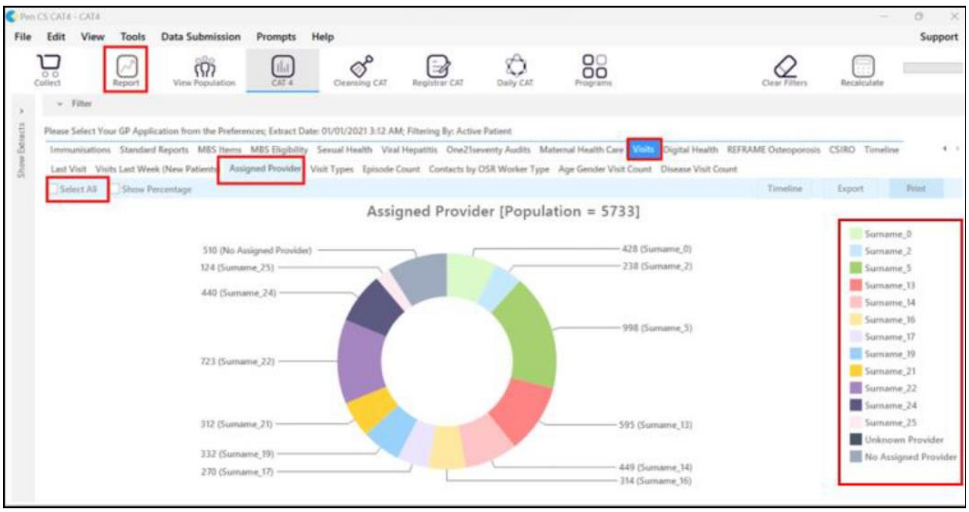
2. **CCM MBS filter (restricts cohort to those who have not had a Care Plan / Review in last "x" period):**
   Under **'MBS Attendance'** → select **'Any of selected'** → select **'No' to 721, 723 or 732 (and 965/967 after 1 July 2025)**
   Optional: Under **'MBS Attendance'** → select 'Claim Date Range' for example:
   - '≤12months' (care plans not billed in the past 12 months)
   - '≤6 Months' (care plans reviews not billed in the past 6 months)
   - Date Range (from – to): 11/3/25 – 11/6/25 (care plan reviews not billed in the past 3month)



3. Recalculate

➢ **In Report Panel**

4. Under "Visits" → go to "**Assigned Provider**" → select provider/s or "Select All"



CPD Measuring Outcome Tip
Work as a team to generate a **CAT4 list of patients per GP**.

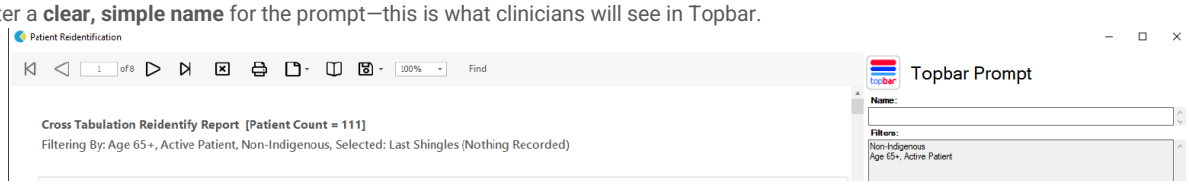
5. **Optional**: Select Export → XLS File → Save *(e.g. Create a folder C:/ClinicalAudit/CAT Patient FollowUp)*

3.7 Activity – Create a prompt to display in Topbar

1. Open **Daily View** in CAT4. Ensure **Topbar is installed** and **linked via Edit > Preferences > Topbar**.

2. Apply filters to display your target patient list.
3. At the bottom of the Patient Details Report, select **"Prompt at Consult – Topbar"** and click **"Go"**.

4. Enter a **clear, simple name** for the prompt—this is what clinicians will see in Topbar.

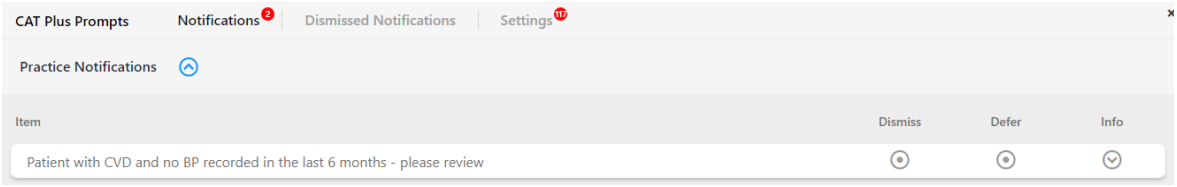


For more information, refer **Using Topbar Prompts in Recipes**

Topbar Applications

Full details for all Topbar apps can be found **here**

1. Once a patient matches prompt criteria in the clinical system, the CAT Prompts App in Topbar displays a red-circle notification.
2. Clicking the prompt reveals details like the reason by ⌄ and relevant patient data.



Waiting Room App
Displays patients in the Waiting Room with missing data.

- **Reception use:** Highlights missing demographics.
- **Clinical tab:** Shows missing clinical/ accreditation items (e.g. allergies, smoking, risk factors) for updates needed for accreditation and PIP QI.

Data Cleansing App

- Displays missing demographic/clinical data and uncoded chronic conditions.
- Helps clean free-text diagnoses and improve disease registers.
- Designed for consult rooms; shows one patient at a time.

MBS App
Alerts users to potential MBS item eligibility, including

- Health Assessments,
- Chronic Conditions Cycles of Care,
- Medication Reviews,
- Care Plans
- Care Plan reviews.

CAT Plus Prompts
Create custom alerts in CAT4 to display in Topbar when patients present, helping teams address care gaps, identify risks, and support QI efforts.

Patient Health Summary
Provides a quick overview of key health info (e.g. meds, allergies, history, risks) as required by RACGP 5th Edition Standards—accessible with one click.

Learn how to use Topbar by clicking the image below to watch a **beginner's video tutorial**

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.

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.

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 patient 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 per Year	Annual amount billed per patient	Annual amount billed per patient
GPCCMP MBS 965 or 92029	1	$156.55	
GPCCMP Review MBS 967 or 92030	3	$469.65	
Nurse/ AHP follow up 10997	3-5	$40.95 - 65.25	$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 **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

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 plan MBS 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

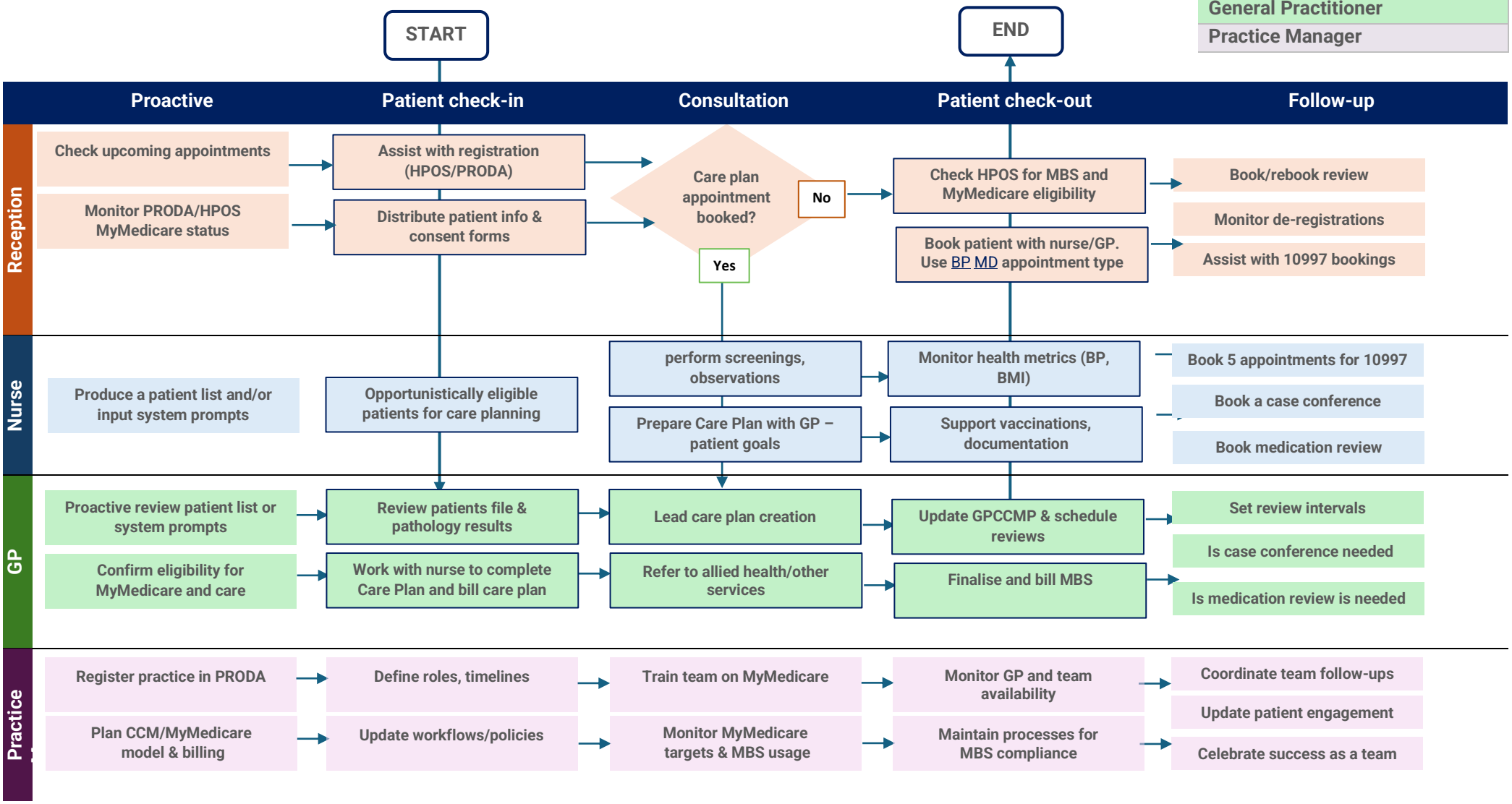
Social Work Referral
Consider this where there is social issues where additional support would benefit chronic condition outcome.

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 CCM Nurse workflows

Pre-Rollout

Team Meeting

- Raise awarness about the change
- Agree on educational resources

- Clear communication channels internally (WhatsApp)

Create leadership team:
- Principle GP
- PM
- CCM nurse

Meeting Topics:
- Better Patient Care
- Operational Efficiency
- Financial Optimisation
- Implementation Path

Practices with CCM nurse

GP/s
- Get patient's consent after nurse prepares Care Plan
- Providing 3 months review if clinically appropriate
- New Care Plan to be created if significant change to patient's health conditions
- Finalise MBS item/s for receptionists to bill

Nurses
- Prepare Care Plans
- Setting reminders for future reviews
- Booking pateints for health assessments if required
- Patient education focused personal goals / reviews / care plans/ mymedicare registration/ checkups
- Utilising HealthPathways/ GoShare

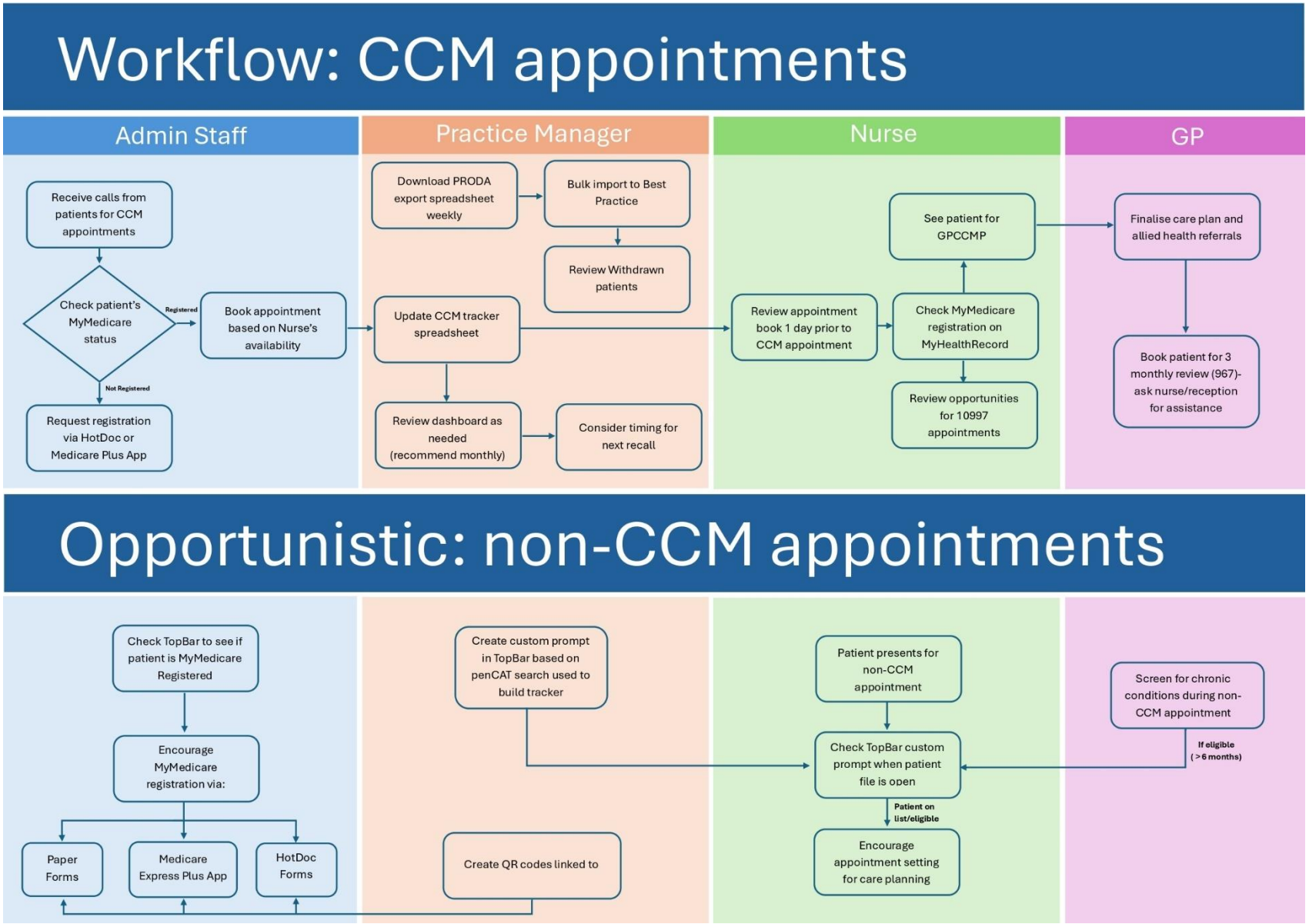
PM
- Cubiko (if applicable) and PenCs data extraction
- Clinical Management System update from the 1st of July
- Setting Monthly meetings and targets
- Put updates in WhatsApp channel
- Supply checklist/ resources
- Providing awareness resources at the practice for patients (posters/ TV/ social media/ website/ newsletter)

Receptionists

Upon patient's arrival:
- Coordinate PRODA access
- Check PRODA / My Health Record and MBS eligibility for each patient
- MyMedicare registration

Patient
- Maintain MyMedicare registration at nomiate practice especially for Chronic condition Management
- Monitor number of Allied health visits claimed via Medicare Express App.

4.6 Activity – CCM Appointment workflows



Appendices

5.1 Quality Improvement documentation

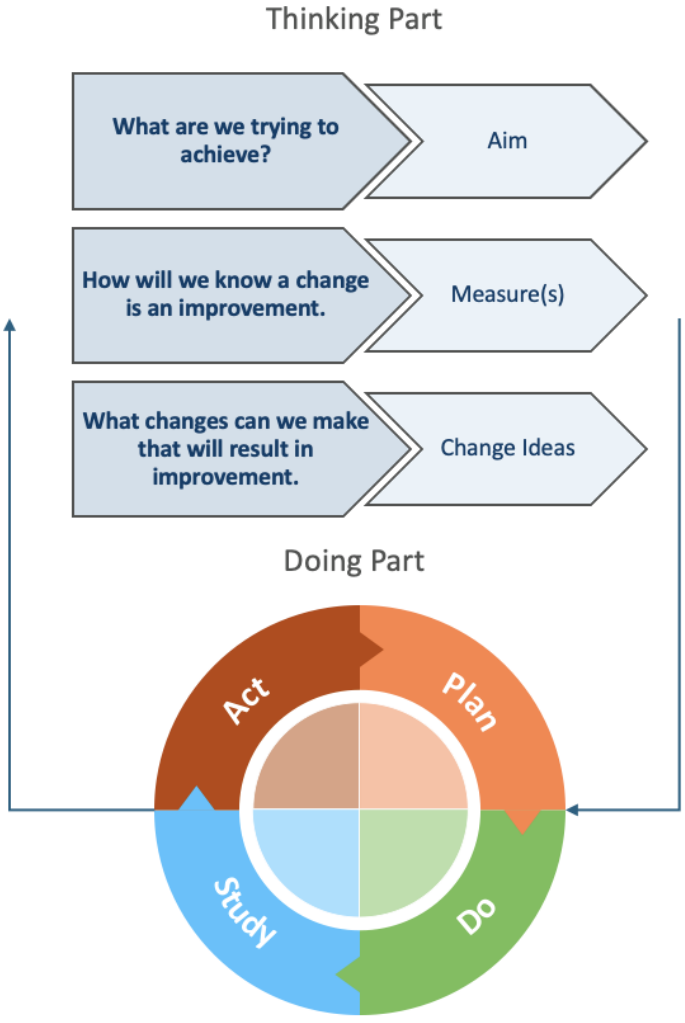
Start by documenting **your practice QI team** and define your problem and specified a robust ***Problem Statement***.

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 support@wentwest.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 & 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. CAT4) 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 CAT4 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 CAT4 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 CAT4, 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 CAT4 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 CAT4 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 12m						
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*

Measuring Outcome CPD Tip: Collaborate as a team to generate a **CAT4 list of patients per GP.**

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

WentWest - WSPHN	02 8811 7117 **support@wentwest.com.au** **www.wentwest.com.au**
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 eLearninghttps://www.health.gov.au/our-work/increases-to-bulk-billing-incentive-payments**
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**
Health Identifiers Service	1800 762 993 **www.pencs.com.au** **support@pencs.com.au** Booking for installation: **support online** Training: **Recorded webinars**: Searches: **CAT4 recipes**
Medical Director	**1300 300 161** **www.medicaldirector.com**
Best Practice	**1300 40 1111** **www.bpsoftware.net** **support@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**
WSLHD GP Support Line	**1300 972 915** **Direct Access to Rapid Access Stabilisation Service; Diabetes, Cardiology and Respiratory**
WSLHD Public Health Unit	**02 9840 3603** Cold Chain Breach/Vaccine Enquiries
Urgent Care	**1800 022 222** (Healthdirect)

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
- Topbar MBS app

More information
- www.mbsonline.gov.au
- Contact MBS 13 21 50 askMBS@health.gov.au
- Western Sydney 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.	
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.

Darug Land, 1/160 Hawkesbury Road Westmead
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WentWest the Western Sydney Primary Health Network