National MyMedicare PHN Implementation Program

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An Australian Government Initiative

CCM General Practice Activity 1

17 Jan 2025

Activity 1 – New Year CDM Resolutions

As the new year rolls around, many of your existing patients with chronic disease management plans will be due for a new chronic disease management plan and team care arrangements. Patients and practices often time chronic disease management plans with the start of the calendar year, when allied health items available through team care renew (items 10950 to 10970 and 81100 to 81125).

This presents your practice with an opportunity to reduce your future workload, and take essential small and easy steps toward preparing for Chronic Conditions Management (CCM) MBS item changes.

Two of the major changes signaled include MyMedicare Registration, and more regular reviews for patients with chronic conditions.

The following activities therefore focus firstly on strengthening patient-practice relationships by registering Chronic Disease Management Patients for MyMedicare, and routine scheduling of patients for Chronic Disease Management Reviews.

There are a range of ideas outlined below for you to use to tailor and modify to develop your own plan for change at your practice. We suggest you document your plan for each Activity Idea below using a Plan-Do-Study-Act Template. Ensure responsibility for each activity is allocated to a member of your practice team with a timeline for completion.

Activity Outcomes

1) Register all returning Chronic Disease Management Patients for MyMedicare with your practice prior to, or at their next Chronic Disease Management appointment.
2) Develop a process for booking future review appointments for any patient you put onto a Chronic Disease Management Plan.
3) Develop a clear communication for why review appointments are important to attend for your practice team and patients (including if there are out of pocket costs for the patient).
4) Develop a process to manage missed or cancelled patient review appointments.

Activity Ideas

1) **Register all returning Chronic Disease Management Patients for MyMedicare with your practice prior to, or at their next Chronic Disease Management appointment.**
    a. Prompt your patients to register in advance of their appointments.
        i. Send an SMS to all patients with a scheduled Chronic Disease Management Plan encouraging them to register with your General Practice before their appointment using Medicare Online or print and complete a MyMedicare Registration form to bring to their appointment, or
        ii. Invite patients to attend their appointment early to complete a MyMedicare Registration Form in the practice waiting room.
    b. Encourage your patients to register at their next appointment
        i. Check each patients' MyMedicare Registration status with your practice when they present for their appointment or the day before their appointment
        ii. Provide a MyMedicare Registration QR code or MyMedicare Registration form when patients present to the practice, and encourage them to complete their registration, or discuss registration as part of their Chronic Disease Management appointment

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iii. Have your practice nurse or Aboriginal Health Practitioner assist the patient with completing the registration for as part of their Chronic Disease appointment. This provides an opportunity for a conversation about expectations of an ongoing care relationship so that the practice can support the patient's health journey in the long term.

2) **Review and strengthen your process for booking review appointments for any patient you put onto a Chronic Conditions Management Plan, or with an existing Chronic Disease Management Plan.**
   a. Consider and develop a method for how your practice will approach scheduling review appointments. You may decide to adopt a standard 3-month review or 6-month review approach or require the clinical team to advise on the review timelines informed by their clinical judgement on a case-by-case basis.
   b. Develop workflows for reception – to ensure that as the patient is handed over to reception before they leave your practice reception has an action to schedule their next appointment, understands the timeframe for review to inform scheduling, and communicates the appointment time and date clearly to the patient (SMS, or reminder card, or other)
   c. Develop a process for appointment reminders in leadup to review appointments – frequency (e.g. 1 week and 24 hours) and modality (phone call or SMS) to ensure your attendance rates for review appointments remain high. Include message for patient to check Medicare Online to ensure they are registered for MyMedicare with your practice, document any questions to bring to the appointment.

3) **Review and strengthen communication for why review appointments are important to attend for your practice team and patients (including if there are out of pocket costs for the patient).**
   a. Review your process and strengthen how you document priorities and actions due for the next review appointment in the patients' medical record in your practice software as part of all Chronic Disease Management Plans and Reviews. For example, document any:
      i. Outcomes, goals or targets the patient has for their review appointment
      ii. Education or points of discussion planned for the review appointment
      iii. Tests or pathology due that need to be scheduled
      iv. Referrals that need to be completed
   b. Communicate the importance of the review appointment with your patient and their carers (if appropriate) including:
      i. Emphasize the importance of the review plan focusing on actions for the patient and why the review is needed with your patient at the conclusion of the appointment
      ii. Provide patient with a printed copy of the care plan and review appointment plan
      iii. Outline expectations and processes to re-schedule review appointment ahead of time
   c. Develop messaging for patients about the benefits of proactive care, care when you are not acutely unwell, or keeping you well. Develop communications to support this in your practice, for example:
      i. Waiting room posters targeting CDM patients
      ii. Talking points for the practice team to reinforce the importance of reviews and attending for care when patients are not acutely unwell.

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4) **Review and strengthen your process to manage missed or cancelled patient review appointments.** Document the process for how to manage cancellations or missed review appointments. As part of this process consider:
    a. How is the cancellation or non-attendance documented? For example, will your practice flag the patient, or retain a list of patients that need to be re-scheduled?
    b. Who needs to be notified? (e.g. Nurse or Aboriginal Health Practitioner with responsibility for Chronic Disease coordination, and the patients usual GP)
    c. What are the standing arrangements for re-scheduling CDM review appointments? For example, does your practice aim to re-schedule within 2 weeks of the cancellation or follow up non-attendance with a phone call to reschedule as a standard operating procedure?
    d. Are there any data searches that need to be completed at regular intervals to identify any patients that may have missed their appointment but not been re-scheduled? For example, you could run a report from your clinical practice software for patients that have not had a review in more than 6 months and provide this list to a Nurse or Aboriginal Health Practitioner with responsibility for Chronic Disease coordination for review and action to check for any patients that have missed their scheduled review.