Chronic Conditions Management readiness: Identifying the roles of the practice team

Every member of the practice team has a role in supporting patients with chronic conditions. Having a coordinated approach, with each person knowing the part they play, improves the patient experience and streamlines care.

With the changes to Chronic Conditions Management (CCM) plans, and the importance of MyMedicare in this process, it is a good time to also define the role each member of your team has in discussing and registering your patients.

Our activity on MyMedicare readiness for CCM can support this work.

Goal: Have a team approach to CCM in your practice, with defined roles for each team member

You could engage with your practice team to explore and document roles and responsibilities related to CCM.

1. Explore roles and responsibilities with the practice team in a meeting or quick lunchtime discussions.
2. Document agreed roles and responsibilities and communicate this with your team.
3. Discuss and document how each team member will incorporate responsibilities into their workday and work week.
4. Schedule a time to review your documented roles and responsibilities.
	1. Check in with your practice team four weeks after publishing these for a quick reflection and to maintain momentum as people adapt to their new responsibilities.
	2. Review team roles and responsibilities at three months and make any changes or improvements based on lessons learned.

An example of potential roles and responsibilities for team members is included below. You can use this as a starting point for discussion or use the blank template below to openly seek contributions from your practice team.

Team roles in general practices template

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| **Practice team member** | **CCM role and responsibilities** |
| ***Practice manager*** |  |
| ***Practice principal*** |  |
| ***Practice nurse, Aboriginal and Torres Strait Islander health practitioner*** |  |
| ***Patient’s nominated general practitioner*** |  |
| ***Reception team*** |  |
| ***Allied health*** |  |

Role and responsibilities examples

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| **Practice team member** | **CCM role and responsibilities** |
| ***Practice manager*** | * Business planning with the practice principal to establish preferred CCM model of care and billing procedures.
* Work with the practice team and principal to determine roles and responsibilities to support comprehensive CCM for patients.
* Engage and communicate to coordinate teamwork for CCM.
* Document policy and procedures to describe how the practice supports proactive care for CCM.
* Maintain up-to-date patient registers of patients with chronic conditions.
* Undertake audits of practice records to identify patients eligible for CCM plans or reviews, investigations, immunisation or screening.
* Establish and oversee recall/reminder systems.
* Support GPs with the flow of CCM information.
* Support and manage reception staff responsibilities.
* Manage succession planning.
* Monitor progress against quality improvement improvement measures
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| ***Practice principal*** | * Work with the practice team and manager to determine clear roles and responsibilities to support comprehensive CCM.
* Business planning with the practice manager to establish preferred CCM model of care and billing procedures.
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| ***Practice nurse, Aboriginal and Torres Strait Islander health practitioner*** | * Work with reception staff to promote CCM.
* Respond to recall/reminder systems and engage in opportunistic discussions with eligible patients to encourage participation.
* Work up, document and contribute to CCM plans.
* Review documentation and discuss with patients.
* Clearly document timelines, actions, investigations, goals and areas of focus for care in preparation for the next CCM. Review, confirm and communicate these with the patient and care team.
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| ***Patient’s nominated general practitioner*** | * Respond to recall/reminder systems and engage eligible patients in opportunistic discussions to encourage CCM participation.
* Review appointments.
* Clearly document timelines, actions, investigations, goals and areas of focus for care in preparation for the next CCM review. Confirm and communicate these with the patient and care team.
* Support eligible patients to participate in screening or vaccinations, including addressing potential barriers such as fear, embarrassment, lack of knowledge, access.
* Perform measurements, screening, immunisations or work with practice nurses to do so.
* Maintain RACGP Standards for General Practice - Criterion GP2.2 – Follow-up systems
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| ***Reception team*** | * Schedule review appointments for CCM patients based on practice procedures and clinical recommendations of GP and nurses.
* Respond to recall/reminders opportunistically when a patient phones for an appointment. Hand relevant resources to patients in the waiting area.
* Send GP-signed recall/reminder letters, text messages or make phone calls to eligible patients.
* Provide translated resources and support information when needed.
* Manage review appointment cancellations, notifying care team.
* Seek guidance when rescheduling appointments to ensure regular care delivery.
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| ***Allied health*** | * Work with the practice team and manager to determine clear roles and responsibilities to support comprehensive CCM.
* Business planning with the practice manager to establish preferred CCM model of care and communication preferences.
* Engage recall/reminder systems and engage in opportunistic discussions to encourage participation with eligible patients.
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We acknowledge the peoples of the Kulin nation as the Traditional Custodians of the land on which our work in the community takes place. We pay our respects to their Elders past and present.