WORKBOOK FOR GENERAL PRACTICE

Continuous Quality Improvement

Chronic Condition Management

EDITION 1 | JULY 2025

phn
NORTH WESTERN MELBOURNE
An Australian Government Initiative

We acknowledge the Traditional Owners of Country across the various lands on which we live and work. We recognise Aboriginal and Torres Strait Islander peoples' continuing connection to land, water, and community and we pay our respects to Elders past and present. We acknowledge Sovereignty in this country has never been ceded. It always was, and always will be, Aboriginal land.

We also recognise, respect and affirm the central role played in our work by people with lived experience, their families and/or carers.

Artwork by Bayilla Creative

Acknowledgements

North Western Melbourne Primary Health Network (NWMPHN) acknowledges that this resource is based on the QI toolkit developed by and under copyright of 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. This workbook has been updated for the NWMPHN region with permission from WentWest.

We acknowledge that some resources used or referenced within this toolkit are from organisations including the Department of Health, Disability and Ageing (DHDA), Services Australia, Royal Australian College of General Practitioners (RACGP); Best Practice; and Medical Director. These organisations retain copyright over their original work. Referencing of material is provided throughout.

Disclaimer

While DHDA has contributed to the funding of this material, the information contained in it does not necessarily reflect the views of the Australian Government and is not advice that is provided or information that is endorsed by the Australian Government. The Australian Government is not responsible in negligence or otherwise for any injury, loss or damage arising from the use of or reliance on the information provided in this toolkit.
The information in this toolkit does not constitute medical advice and NWMPHN accepts no responsibility for how the information in this toolkit is interpreted or used.

You are free to copy and communicate the work in its current form, as long as you attribute WentWest as the source of the copyright material.

Feedback

The information in this document will need to be updated regularly. Please contact NWMPHN on primarycare@nwmphn.org.au if you have any feedback regarding the content of this document.

Contact us

North Western Melbourne Primary Health Network

primarycare@nwmphn.org.au

(03) 9347 1188

nwmphn.org.au

Navigating this 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.

This toolkit includes practical, flexible activities that are **not sequential**.
We recommend starting with the **Practice readiness checklist (.pdf)** to assess your current state.

Contents

Introduction

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

The major changes are to the **MBS framework** for chronic disease management in primary care. These changes implement the **recommendations** of the MBS Review Taskforce.

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).

61%

of Australians are affected by chronic conditions

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.

MBS change item and fee

Service	GP Item Number	Fee	Replacing
Prepare plan - face-to-face	965	$156.55	721 and 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 continue to assist in preparing or reviewing a plan.
- A plan can be prepared once every 12 months, and reviews can occur every three months. A new plan each year is not required - existing plans can be reviewed ongoing.
- Domiciliary medication management reviews will require patients to be under a GPCCMP from 1 July 2027.
- Multidisciplinary care plan items (e.g., for aged care) remain unchanged.
- Current plans remain valid during a two-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 longer a need for two collaborating providers - this requirement has been removed.
- Collaborating providers no longer need to be consulted during the plan creation.
- 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.

Module 1:
Leadership: preparing your practice

On completion of this module, you will:

- Evaluate your practice's readiness to implement MyMedicare and Chronic Condition Management.
- Engage the entire practice leadership team to confirm MyMedicare registration status and ensure readiness for the transition.

Activity navigation

1.1 Practice readiness checklist

1.2 Preparing for change prompts

1.3 Communication action plan

1.4 Practice change (QI) plan

1.5 Practice meeting template

MyMedicare and Chronic Conditions Management (CCM) foundations

MyMedicare is a Voluntary Patient Registration 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.

Registration in MyMedicare is voluntary for patients, practices and providers. **Eligible practices** can register for MyMedicare and begin enrolling **eligible patients**.

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 six 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 – MyMedicare**
- **MyMedicare Practice Registration Guide**
- **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**
- **Melbourne HealthPathways**
- **RACGP - Chronic disease**
- **RACGP – Preventive Activities (the Red Book)**

Module 2:

Patient registration and engagement

On completion of this module, you will:

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

Activity navigation

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

At the heart of both **MyMedicare** and Chronic Conditions Management (CCM) is person-centred care – health care 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.

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.

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.

MyMedicare patient registration:

1. **MyGov mobile App**
2. **Medicare online - MyGov Account**
3. **Paper registration form**, submitted in person at your practice. Pre-filled templates can be found in your practice software's letter writer function.

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

Learn more
Managing MyMedicare registrations – eLearning

Patient resources:

- **MyMedicare - DL brochure**
- **MyMedicare - Easy read brochure**
- **MyMedicare - Poster 1**
- **MyMedicare - Poster 2**
- **MyMedicare - Poster First Nations**
- **MyMedicare - Community information kit**
- **Introducing MyMedicare video**
- **Registering in MyMedicare video**
- **MyMedicare - Social media tile**

Module 3:

Data-driven improvement

On completion of this module, you will:

- Use **POLAR** to drive proactive care. All activities in this module use POLAR 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.

Activity navigation

3.1 POLAR guide – Check patients registered/not registered for MyMedicare

3.2 POLAR guide – All patients due for a care plan and/or reviews

3.3 POLAR guide – Patients with risk of hospitalisation eligible for care plan or review

3.4 POLAR guide – Apply filters in POLAR

3.5 POLAR – WALRUS guide

RACGP clinical audit

NWMPHN will soon be offering 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 POLAR is installed and staff are trained to use POLAR tools – use **POLAR walkthroughs** or videos.
- ☐ Clean your data e.g. archive inactive records, remove duplicates.
- ☐ Standardise coding: ensure diagnoses are coded, not free text.
- ☐ Filter by doctor, condition, or age to create a smaller patient list.

Track and reflect

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

Module 4:

Business and team optimisation

On completion of this module, you will:

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

Activity navigation

4.1 Business optimisation for CCM

4.2 Roles and responsibilities for CCM

Use the **Chronic Conditions Management – MBS Quick Guide**

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).

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 three months if clinically relevant	GPs - $156.55 PMPs - $125.30
Review a GP chronic condition management plan - video	92030	92061	Every three months if clinically relevant	GPs - $156.55 PMPs - $125.30

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

MBS ONLINE

- **Search for Item Number**
- **Fact sheets**
- **Updates (XML files)**
- **MBS news**

ELIGIBILITY

Ensure patient meets billing criteria.

- **HPOS MBS checker**
- **My Health Record**

MORE INFORMATION

- **www.mbsonline.gov.au**
- **Contact**
  MBS 13 21 50
  askMBS@health.gov.au

This resource demonstrates the potential use of MBS items related to CCM, for a full explanation of each MBS item please go to **MBS online**.

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

Appendices

Links to Activities

PDSA template

5.1 Quality Improvement documentation

5.2 PDSA ideas – Team awareness, desire and readiness

5.3 PDSA ideas – Identifying Active Patients and Linking to MyMedicare Program

5.4 PDSA ideas – CCM and MyMedicare

5.5 PDSA ideas – Reducing Missed Appointments for Care Plan reviews

5.6 Activity Audit Worksheet

5.7 Group reflection – after completing activities

5.8 Useful contacts

phn
NORTH WESTERN MELBOURNE
An Australian Government Initiative

North Western Melbourne Primary Health Network
(03) 9347 1188

nwmphn.org.au

NWMPHN JULY2025.