HotDoc | WEBINAR

From Efficiency to Continuity: Smarter Consults & Better Patient Care

HOSTED BY
Kim Poyner
Founder
MediCoach

Tue 30th Sep
12:30pm AEST

Before we begin -

- This session is being recorded & you will be sent a link 4-6 hours after this session has concluded with the recording & resources.
- Use the Q&A tool on your screen to submit a questions through the session & we will address at the end. If we don't get a chance to address during the LIVE session, we will reach out to you afterwards to discuss further.
- In the "related content" you'll find our further feedback form.
- Your certificate will be accessible at anytime, you can access via the  certificate icon on your console.
- Have a play around with the console/ icons on your screen, it's an interactive experience.
- Please take some time to complete our feedback survey to let us know what you thought of today's session.

Acknowledgement of Country

HotDoc and MediCoach acknowledge the traditional custodians of the lands on which we meet today and pay our respects to elders past, present & emerging.

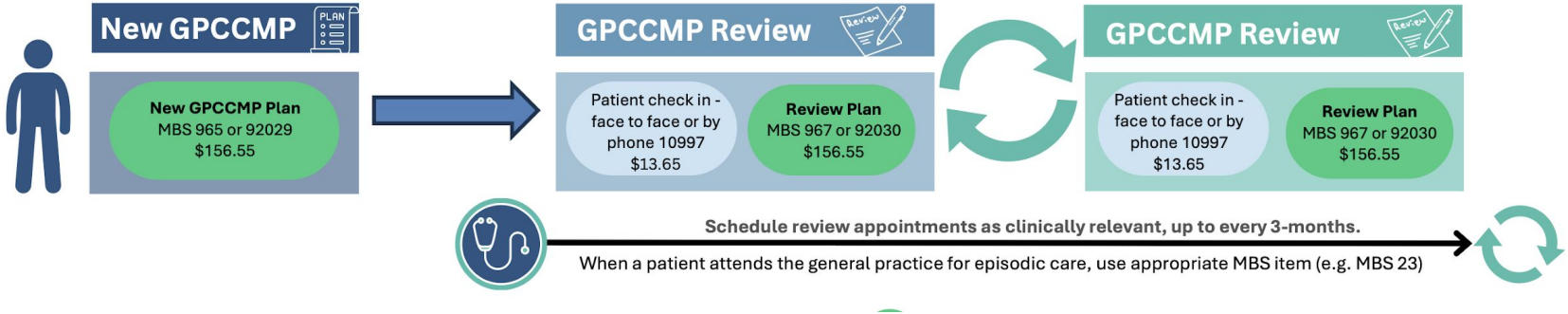
Agenda

- Overview of the GPCCMP program and its progress so far.
- Why efficiency in consults matters for both GPs and patients.
- Practical strategies to streamline consults without compromising care.
- How to engage patients more effectively in their own care journey.
- Reducing consult time through smarter processes and digital support.
- Shifting towards a longitudinal care model—what it looks like in practice.
- Benefits of continuity of care for patient outcomes and practice sustainability.
- Practical tips and takeaways you can apply immediately.
- Q&A with Kim Poyner

Chronic Condition Management Plans and Reviews

National MyMedicare PHN Implementation Program

phn COOPERATIVE
An Australian Government Initiative



New GPCCMP

1.Patient Eligibility

☐ Must have at least **one chronic condition** (≥6 months). No age restrictions.
☐ **MyMedicare status checked. Discuss MyMedicare patient registration to support care continuity with your practice.**

2. Develop Management Plan: Practice Nurse, Aboriginal Health Workers or Practitioners may contribute to preparing the plan - GP must see patient

☐ Explain the management plan process, gain informed consent, and collaboratively identify patient, 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

GPCCMP Reviews

- ☐ Review GPCCMPs no more than once 3 months if clinically appropriate
- ☐ Use MBS item 967 (face-to-face) or 92030 (video)
- ☐ Assess patient progress, update goals and services, record conse
- ☐ Review letters from other providers and note updates in patient fil
- ☐ Provide an updated copy to the patient and carer
- ☐ Share updates with other providers (if applicable)
- ☐ Encourage upload to My Health Record (with consent)
- ☐ Consider future review appointments

The Item Numbers

	GP Rebate $156.55	Prescribed Medical Practitioner (non VR) Rebate $125.30
Prepare plan Face to Face **Once every 12 months** 	965 Professional attendance by a general practitioner to prepare a GP chronic condition management plan for a patient	392
Prepare plan Video **Once every 12 months** 	92029	92060
Review Face to face **Once every 3 months** 	967	393
Review Video **Once every 3 months** 	92030	92061

Primary Care Innovation

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Chronic Condition Management Plans

Billing cheat sheet

GP Provider Face-to-face

			Check MyMedicare registered status	
GPMP or TCA	721 or 723	→	965 only	GPCCMP
CDM Review	732	→	967*	GPCCMP Review

Prescribed Medical Practitioners (Non VR Provider) Face-to-face

			Check MyMedicare registered status	
GPMP or TCA	229 or 230	→	392 only	GPCCMP
CDM Review	233	→	393*	GPCCMP Review

GP Provider Telehealth equivalent

			Check MyMedicare registered status	
GPMP or TCA	92024 or 92025	→	92029 only	GPCCMP
CDM Review	92028	→	92030*	GPCCMP Review

Prescribed Medical Practitioners (Non VR Provider) Telehealth equivalent

			Check MyMedicare registered status	
GPMP or TCA	92055 or 92056	→	92060 only	GPCCMP
CDM Review	92059	→	92061*	GPCCMP Review

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For Patients

Holistic & coordinated care – Patients with multiple or complex chronic conditions receive structured care plans that integrate their GP, nurses, allied health, and specialists.

Better access to services – Eligibility for Medicare rebates on allied health visits makes ongoing management more affordable.

Improved self-management – Patients are supported through health coaching, education, and goal setting, which builds confidence and long-term engagement.

Continuity & prevention focus – Regular reviews ensure proactive monitoring, reducing complications and hospital admissions.

For Clinicians

Structured framework – Provides GPs and practice teams with a clear, Medicare-supported model for managing chronic illness.

Team-based care – Encourages delegation to practice nurses and allied health, reducing GP workload and improving job satisfaction.

Funding support –Allows for other activities to be performed.

Improved outcomes – Evidence shows these programs improve adherence, patient outcomes, and practice efficiency, making clinical care more rewarding.

👉 In short, GPCCMP supports **patients with more accessible, coordinated, and proactive care**, while giving **clinicians a funded, team-based system** that reduces burden and enhances outcomes.

Goal setting - **Behaviour Change Science**

Research shows that behaviour change requires **regular reinforcement**. Six weeks is enough time for patients to trial new strategies, but not so long that momentum is lost.

- Frequent touchpoints help keep patients **accountable** and motivated.

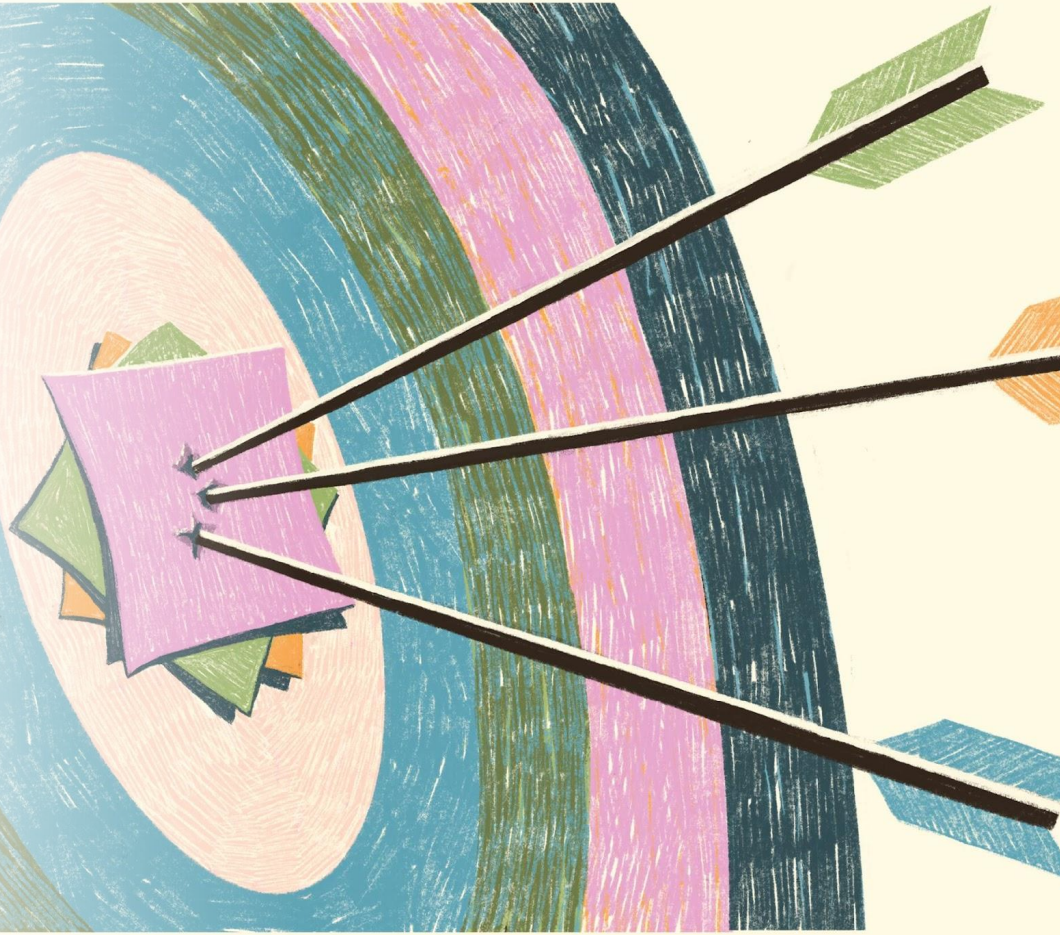
Clinical Safety & Monitoring

- For chronic conditions, 6 weeks is an effective interval to **track progress, adjust medications, and monitor risks** before problems escalate.
- Early intervention at these intervals can prevent hospitalisations or deterioration.

SMART Goals Progression

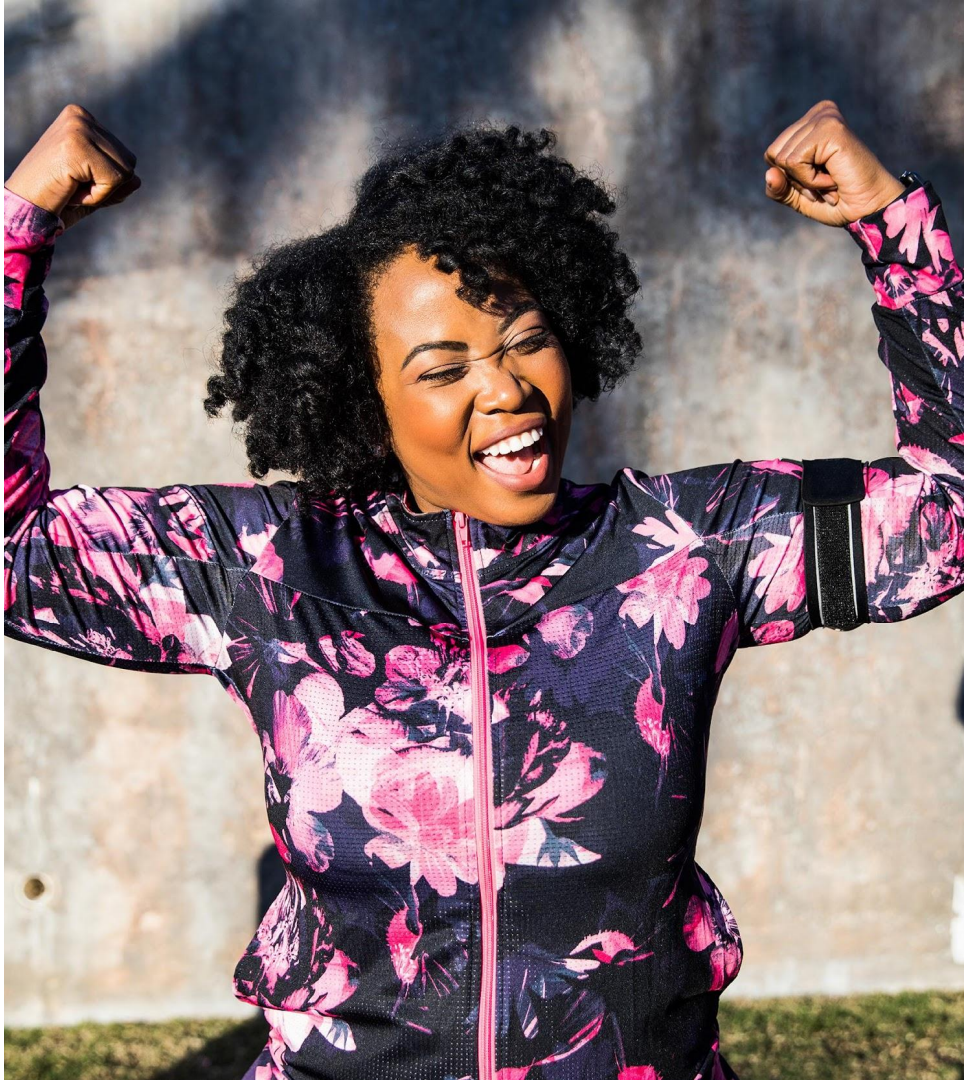
Six weeks allows patients to work on **achievable, measurable steps** toward larger health goals.

Regular review ensures goals remain realistic and relevant as patients' circumstances change.



Case study - Betty

- MyMedicare registered with Dr Bob Jones
- Has had a 965 billed 1st of July and unlocked the GPCCMP process
- Has at last visit had her Ob's taken; Goals set; referrals performed
- Had Nurse Narelle call August 15th Goal review and confirm next appointment and activities that will be conducted
- Today is booked in Health Assessment and CCM review



What do they gain?

Make it concise and efficient.

- 20 minutes

Be clear on who is doing what activities

- Reduce duplication

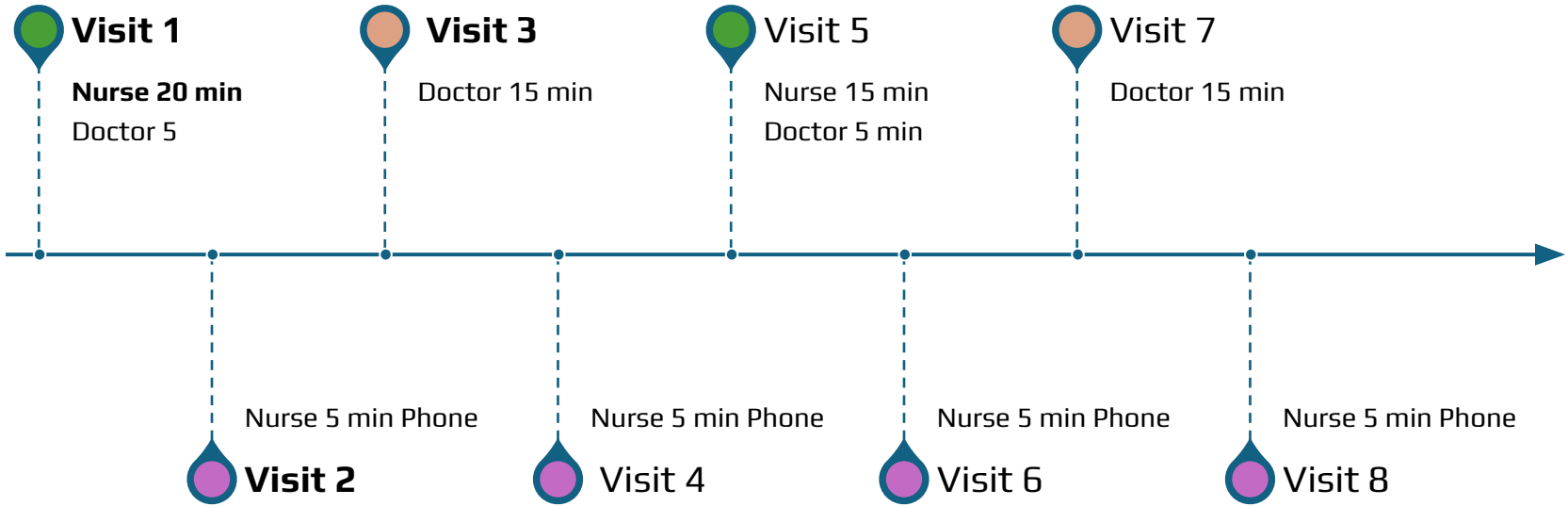
Make it fun with positive questions

- What does that person want for their health and wellbeing?
- What do they gain if they make changes to their health and wellbeing?

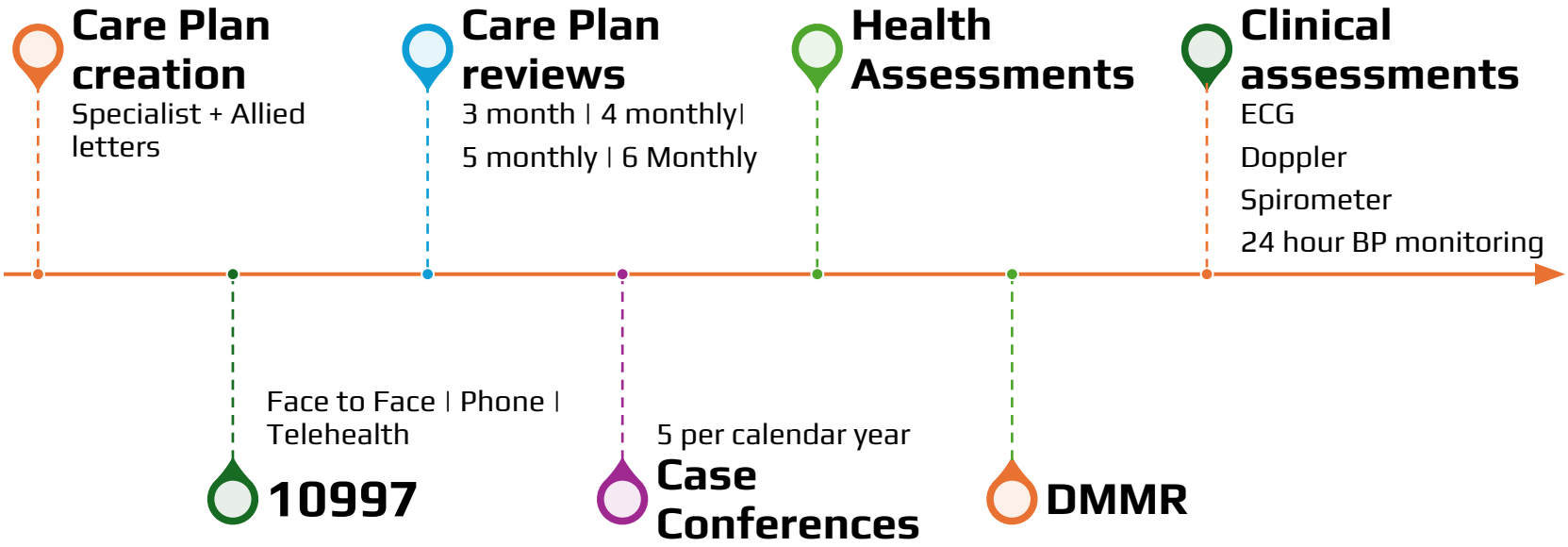
Digital support

- HotDoc
  - Bookings and reminders
- Cubiko
  - What is the patient eligible for at next visit
- Lyrebird scribes
  - Take out the admin burden and create more communication opportunities during the consult

Care Planning Workflow



Extended Workflow



For Patients (Outcomes)

Improved health outcomes – Regular follow-up and consistent goal-setting

Stronger relationships – Seeing the same GP/practice nurse builds trust

Personalised care – Plans are reviewed and updated regularly

Empowerment & self-management – Continuity supports behaviour change.

Better coordination – Care plans link GPs, nurses, and allied health providers

For Practices (Sustainability)

Efficiency & workflow – Structured reviews reduce crisis appointments.

Team-based care – Nurses and allied health professionals can take a greater role.

Financial sustainability – MBS items to do other proactive care

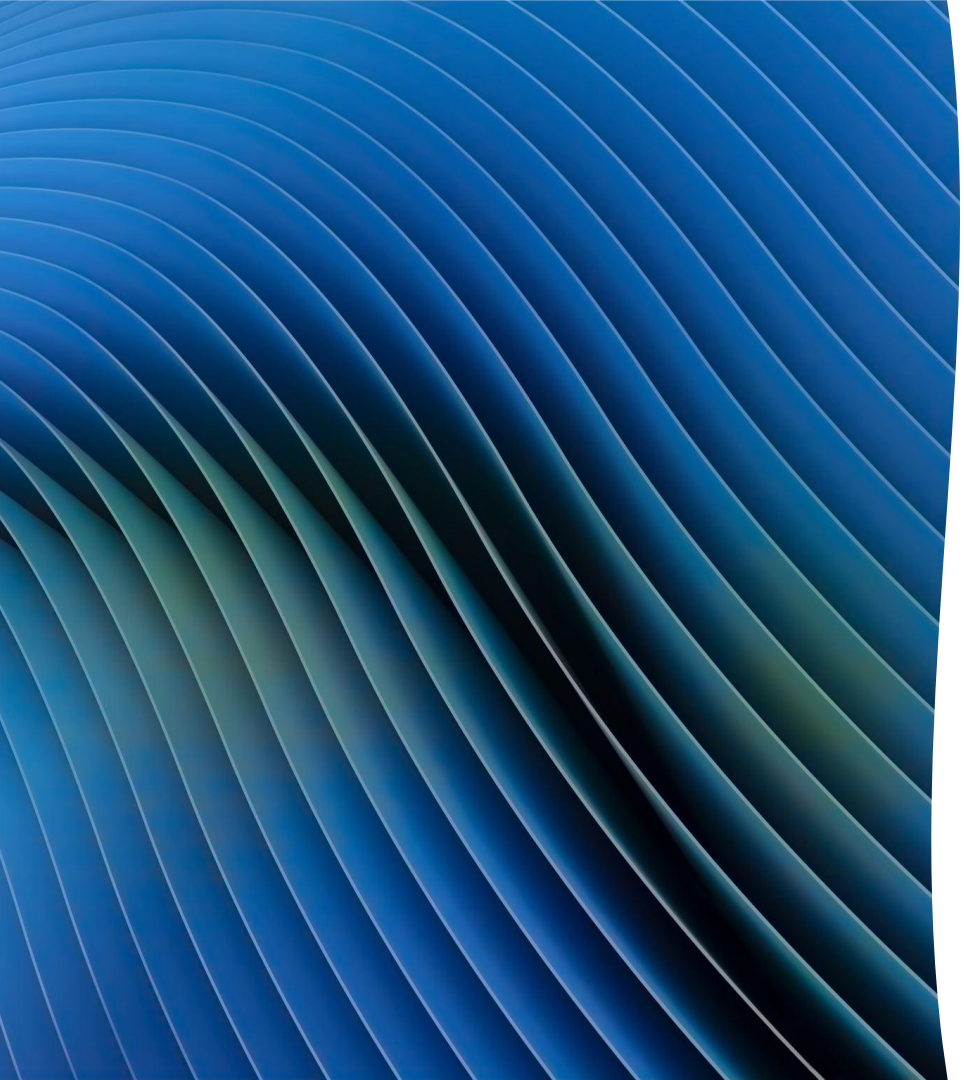
Data & quality improvement – Continuity of care creates measurable outcomes

Patient loyalty & retention – Patients value ongoing, trusted care, strengthening long-term practice-patient relationships.

Case study

- Practice wants to improve Lung screening
- Utilise Clinical software data search for eligibility
- Hot doc to send an invitation for assessment at the practice
- Nurse to check patient's interest and readiness in having lung screening
- Doctor completing referral
- Low dose CT scan performed
- 2 newly diagnosed Lung Cancer patients placed on Care plans and health assessment

https://www.health.gov.au/our-work/nlcsp/about



Practical tips and takeaways you can apply immediately.

- Utilise your digital tools to be a virtual assistant
- Assign roles to create efficiencies
- Utilise the whole team
- Consider what else could we be doing/claiming for this client
- Patients who were used to coming once a year can we entice twice plus other activities
- Skill your team in behaviour change language and make it fun for both patient and staff

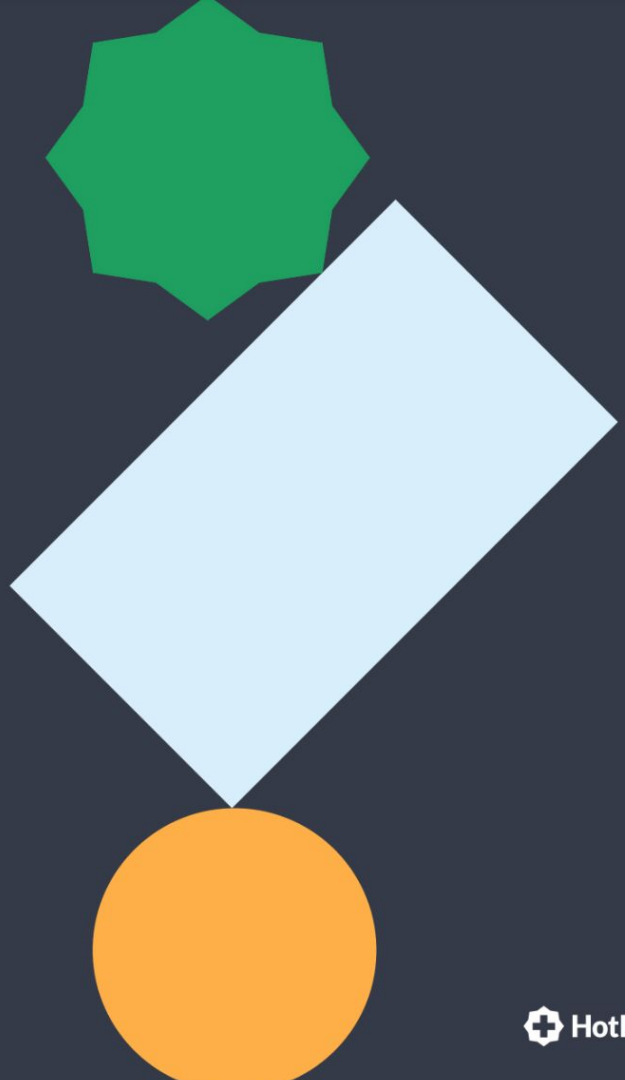
HotDoc | WEBINAR

Driving Better Care: Key Updates on Wound Consumables, Lung Cancer Screening & Better Access Program

HOSTED BY
Wendy O'Meara
Primary Care Consultant

Thur 16th October
12:30pm AEDT

Questions



Thank you for watching