HotDoc | WEBINAR

What We Know About Chronic Conditions Management (CCM)

HOSTED BY
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Founder
MediCoach

Wed 25th June
12:30pm AEST

In the spirit of reconciliation, HotDoc acknowledges the Traditional Custodians of country throughout Australia and their connections to land, sea and community.

We pay our respect to their elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

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.

What We Know About Chronic Conditions Management (CCM/ CDM)

MediCoach June 2025

Acknowledgement of Country

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

Today's Agenda

- Structural Changes to Chronic Care Management (CCM)
- TCA (Team Care Arrangement) Becomes a Referral Process
- New CCM item numbers & billing flexibility
- Client engagement strategies - how to boost attendance & value
- How to highlight the benefits to patients
- Use Proactive Reminders
- How to frame reviews as "Unlocking Value"
- The appeal of team-based care
- Implementation tips for staff & admin
- Q&A with the Kim Poyner

Medicare CCM Changes Coming

- GPMP & TCA to become a single plan
- Patients registered to MyMedicare can only receive CCM services from their registered practice
- Focus on care plan reviews
- Equalising of fees | care plans & reviews
- Referrals to allied health | process consistent with specialists
- Compliance simplification
- Build on your processes & workflows
- 1 July 2025 with transitional arrangements to June 2027

Old

2 plans

TCA collaboration and documents

EPC forms | Changes to names | Alloc. Of visits

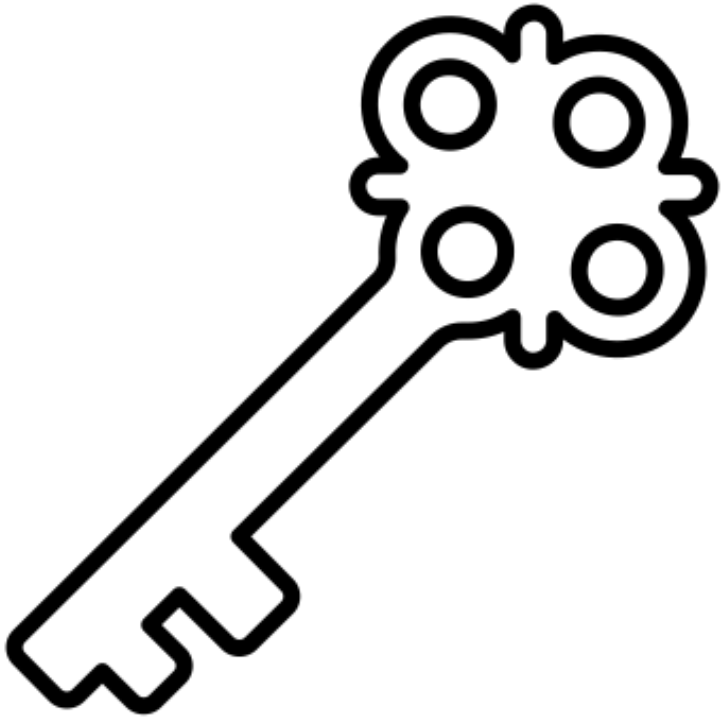
Front loaded funding

Complex Care plans

Less than ½ care plans in Australia were reviewed

New

- 1 plan
- TCA referral letter
- Referral lasts 18 months
- No naming provider just allied discipline (affordability)
- Equalising Fees
- Simplification of a living document
- 3 monthly reviews



Unlocking the Process

- Item number 965 MUST be claimed first
- Transition process in place for 2 years for old plans
    - Pts with existing GPMP/TCA can continue to receive nursing allied health services referred under those plans until 30 June 2027

MyMedicare

Primary Care Innovation

Patients registered to MyMedicare can only receive GPCCMP from their nominated practice

Patients NOT registered can receive GPCCMP from any practice

Referrals

Nurses, AHP & AHW can assist

10997 unchanged

10987 unchanged

Allied health referral – ‘EPC’ not required

- Simple referral letter
- **MUST** claim a 965 first
- 5 Visits unchanged
- 10 visits for patients of Aboriginal/TSI descent
- Group services for patients deemed suitable with type 2 diabetes – up to 8 per year

Collaboration requirements NOT REQUIRED

2+ referrers NOT REQUIRED

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

Cubiko MediCoach

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

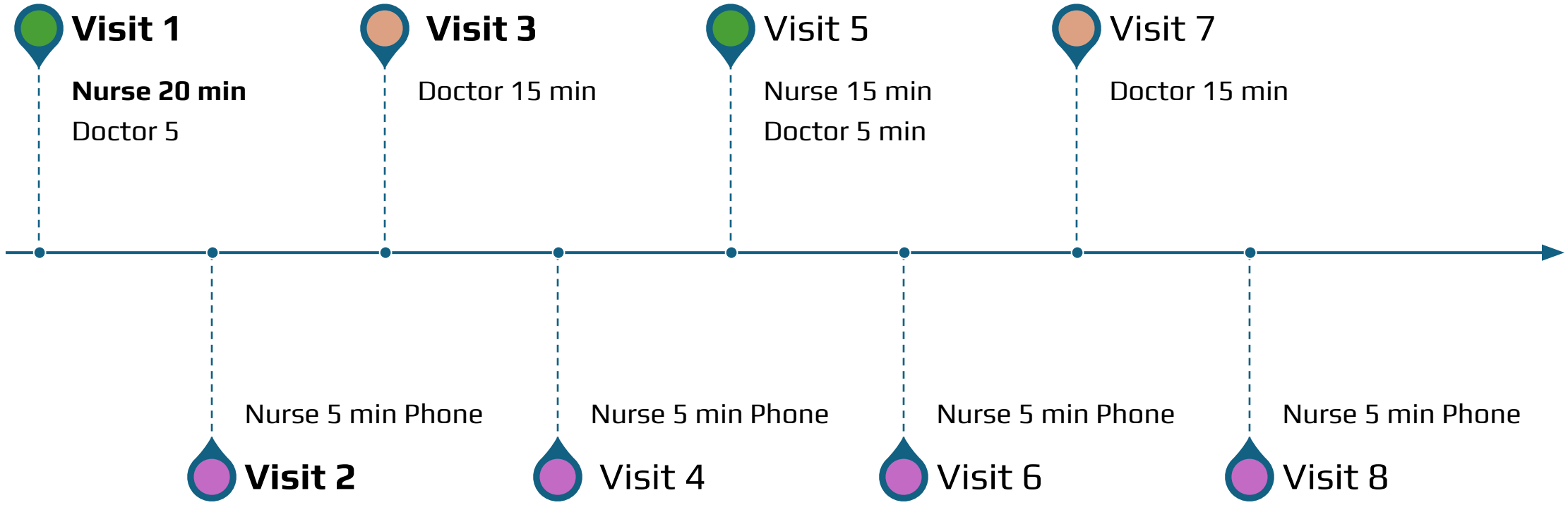
			Check MyMedicare registered status	
GPMP or TCA	92024 or 92025	→	92029 only	GPCCMP
CDM Review	92028	→	92030*	GPCCMP Review

Prescribed Medical Practitioners (Non VR Provider) Telehealth equivalent

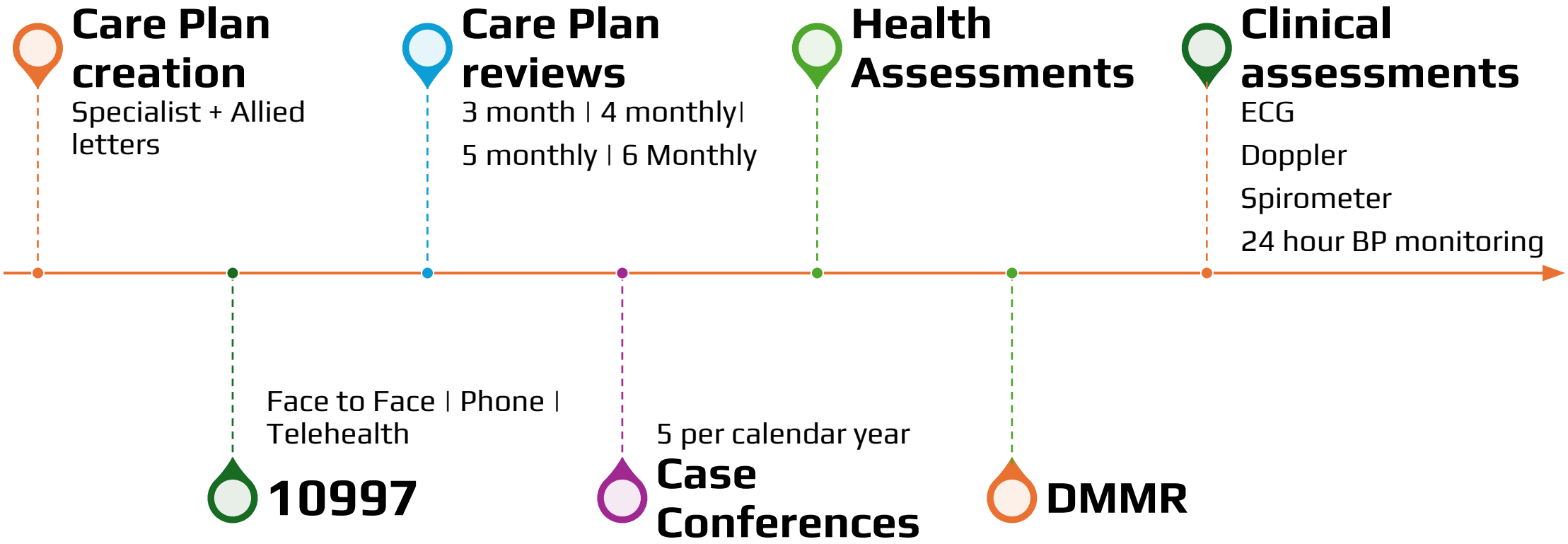
			Check MyMedicare registered status	
GPMP or TCA	92055 or 92056	→	92060 only	GPCCMP
CDM Review	92059	→	92061*	GPCCMP Review

Care Planning Workflow

Primary Care Innovation



Extended Workflow



Engaging Patients to Return to Clinic

Deliver value to patients/'buy-in'

Can you spread activities such as immunisations; ECG; Doppler; Spirometry

Review the patient self managed agreed goals

Develop Coaching skills to enhance care

Use	Reflect	Set	Explain
Open ended questions for Smoking; Nutrition; Alcohol; Physical activity (SNAP)	Empathy and validate	Patient self managed agreed goals 1% more than currently doing • What activity; When; who with; duration • Book a 10997 face to face | phone call equivalent to review	review in 3|6 months • will be about what they enjoyed, what went well and what they learnt

What	WHY – Outcome GOALS
Changes to CDM – one off to at least 2	Match income and better patient outcomes
Finding Patients	Who are we missing as opportunities to put on a care plan
Registering Patients	ALL GPACI + CCM Polar check = only billing from this Medical Practice
Making Billing Viable	Looking at Capacity | Virtual services
Retaining workforce | workflows	Health Assessments | Phone | reviews
Adding in GPACI	Nurse Activities and keeping record of services

What	Why	How
Changes to CDM – one off to at least 2	Match income and better patient outcomes	What has worked previously to engage patients – hold EPC allocation | Dr told me | booked in
Finding Patients	Who are we missing as opportunities to put on a care plan	Keeping registers | Reminders = $
Registering Patients	Preventing bad behaviour | only billing from this Medical Practice	Reception checking Proda at start of shift | registering if required | education
Making Billing Viable	More income = more resourcing for the client's service delivery and workforce capacity building	Looking at Capacity | Virtual services | doing the math
Retaining workforce | workflows	Lots of missed services = increased admissions FFI coming	Health Assessments | Phone | reviews | Data Mining
Adding in GPACI	Less unnecessary hospital admissions | better in hours management	Nurse Activities and keeping record of services

Engage Your Practice Team

1. Engage Your Practice Team

- Team meeting or quick lunch catch up
- Post an update in the practice staff rooom
- Send an email to the practice team

2. Explore MyMedicare Benefits

- Talking points for discussion
- Use MyMedicare GP Toolkit

3. Explore Chronic Conditions Management Changes

Summary of CCM changes

- More information at these links

Chronic Conditions Management (CCM) MBS item changes
MBS Review Taskforce

4. Define and Document Roles & Responsibilities

- Explore roles in meeting or discussion
- Document agreed responsibilities
- Integrate into daily practice
- Check-in after 4 weeks
- Review at 3 months

Nurses

MyMedicare Registration

MyMedicare supports continuity of care and plays a role in long-term care planning.

- Nurses play an important role in reinforcing key messages about MyMedicare and the importance of regular reviews
- Explain how reviews help monitor progress and support long-term care planning
- Highlight the link between MyMedicare registration & eligibility for CCMP services
- Work with the broader team to ensure patients receive clear, consistent messaging across all touchpoints

Scheduling appointments

Appointments should follow practice procedures and GP recommendations.

Two approaches support CCMP scheduling:

Opportunistic engagement
- Identify eligible patients attending today
- Use Care Prompts to prompt GP conversation
- Book patient in for appointment

Proactive engagement
- Use metrics to identify eligible patients
- GPs review, then nurse to book appointments

Missed appointments

Missed appointments affect care continuity. Nursing teams can help by identifying & rebooking patients.

Cancelled Appointments
- Track patients who cancel & haven't rebooked. Follow up to keep care on track

Overdue Reminders
- Identify reminders flagged by GPs that are still pending

Recalls
- View outstanding recalls by status & age

Appointments to rebook
- Find patients with no upcoming CCMP appointment. Prioritise them for rebooking

CCMP & Review documentation

Nurses play a key role in delivering chronic disease care by preparing, coordinating and documenting care plans and reviews.

- Work up and document care plans in line with practice protocols
- Record timelines, goals, actions and relevant investigations
- Discuss plans with patients and confirm next steps with the care team
- Complete clinical tasks and capture key health data to support care planning
- Plan when to carry out clinical tasks across the calendar year to support patient progress

Doctors

MyMedicare Registration

MyMedicare supports continuity of care and plays a role in long-term care planning.

- Practitioners reinforce the importance of MyMedicare during consultations
- Explain how reviews support long-term care, guide goal-setting and track progress
- Highlight the link between registration and access to GPCCMP
- Work with the team to ensure patients receive consistent messaging across care
- Help patients understand how MyMedicare supports structured, personalised care

Scheduling appointments

Appointments should follow practice procedures and clinical judgment.

Two approaches support CCMP scheduling:

Opportunistic engagement

- Use Care Prompts to identify eligible patients & have meaningful conversations
- Encourage booking a follow-up before the patient leaves

Proactive engagement

- Review patient lists prepared by the team
- Identify patients for GPCCMP items
- Advise reception to book appointments

Missed appointments & overdue reminders

Missed appointments affect care continuity. Practitioners support continuity by helping the team manage missed or delayed care.

- Review lists from reception or nursing to flag follow-up needs
- Reinforce the value of reviews and ongoing care during appointments
- Respond to recalls and reminders in the PMS
- Encourage patients to stay engaged in chronic care
- Help prevent patients slipping through the cracks

CCMP & Review documentation

Practitioners are central to the planning and delivery of chronic disease care, playing a key role in preparing, coordinating and documenting care plans and reviews.

- Set or review goals with the patient and confirm understanding
- Record agreed actions, referrals, investigations and timelines
- Update progress notes and key health data in the medical record
- Confirm next steps with the care team
- Identify new CCMP candidates using Cubiko and start the conversation

Practice Managers

MyMedicare Registration

MyMedicare supports continuity of care and plays a role in long-term care planning.

- Understand the benefits for patients with chronic conditions and the broader practice
- Review your model of care, billing practices & internal procedures for CCMP to align with Practitioner preferences
- Establish clear roles across your team to support consistent, proactive care
- Use tools like Cubiko to identify eligible patients and support smooth registration processes

Scheduling appointments

Appointments should follow practice procedures and GP recommendations.

- Ensure clear processes are in place for both opportunistic and proactive CCMP scheduling
- Support the use of Care Prompts to identify eligible patients during routine visits and encourage timely rebooking
- Oversee the use of Item Optimisation metrics and ensure appropriate follow-up
- Review scheduling patterns to support timely reviews and align with clinical and Providers billing preferences.

Recall and Reminder workflows

Establishing and maintaining an effective recall and reminder system is essential to ensure patients remain engaged in their ongoing care.

- Use Cubiko metrics like Cancelled Appointments, Appointments with no rebookings and Overdue Reminders to track follow-up needs
- Monitor recall appointments to guide rebooking
- Ensure workflows are documented, roles are clear and regular auditing supports ongoing improvement

CCMP & Review documentation

Ongoing monitoring and improvement are key to sustaining a successful CCMP program.

- Conduct regular audits to identify patients due for GPCCMPs, reviews, immunisations or screenings
- Use Cubiko dashboards to track delivery, spot trends and address workflow gaps
- Share insights with the team to drive improvement, maintain momentum and recognise progress
- Support clear communication between clinical and operational teams to ensure coordinated care

Receptio n

MyMedicare Registration

MyMedicare supports continuity of care and plays a role in long-term care planning.

Possible Service Opportunities

- Identify eligible patients attending today
- Check MyMedicare status and send SMS or invite to register in-practice

MyMedicare eligible patients with an appointment today

- View all eligible patients booked today
- Use for broader outreach and registration support

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Overdue Reminders

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Patient communication

Reception supports clear communication about reviews and MyMedicare, reinforcing messages shared by the clinical team.

Patient messaging

- Explain MyMedicare benefits and eligibility when booking. Share any out-of-pocket costs up front to manage expectations.

Practice tools

- Use posters and team talking points to highlight the value of reviews and MyMedicare registration in supporting ongoing care.

MediCoach | Cubiko | Medical Business Services Resources page

Accessing Additional Support

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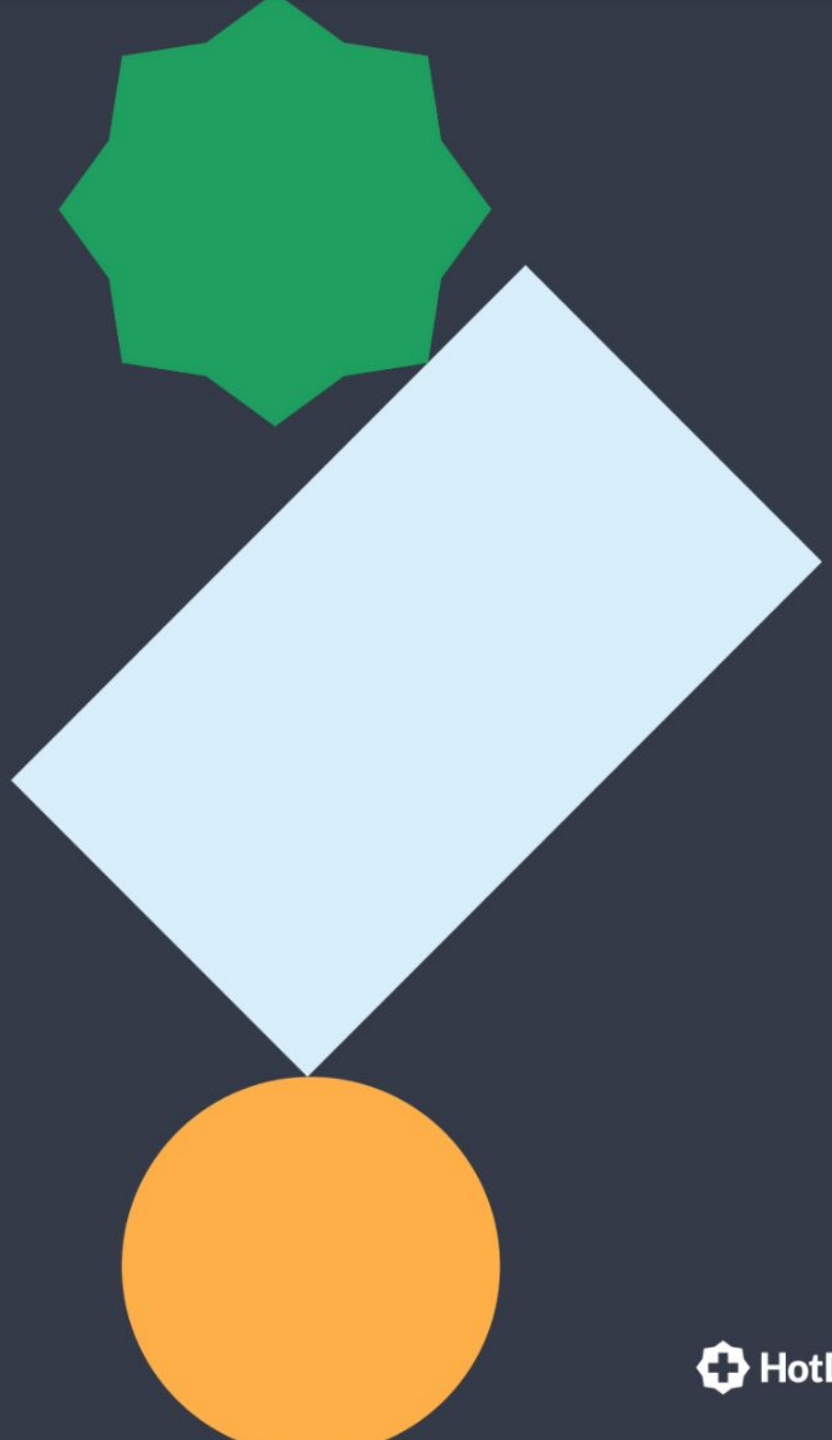
Questions



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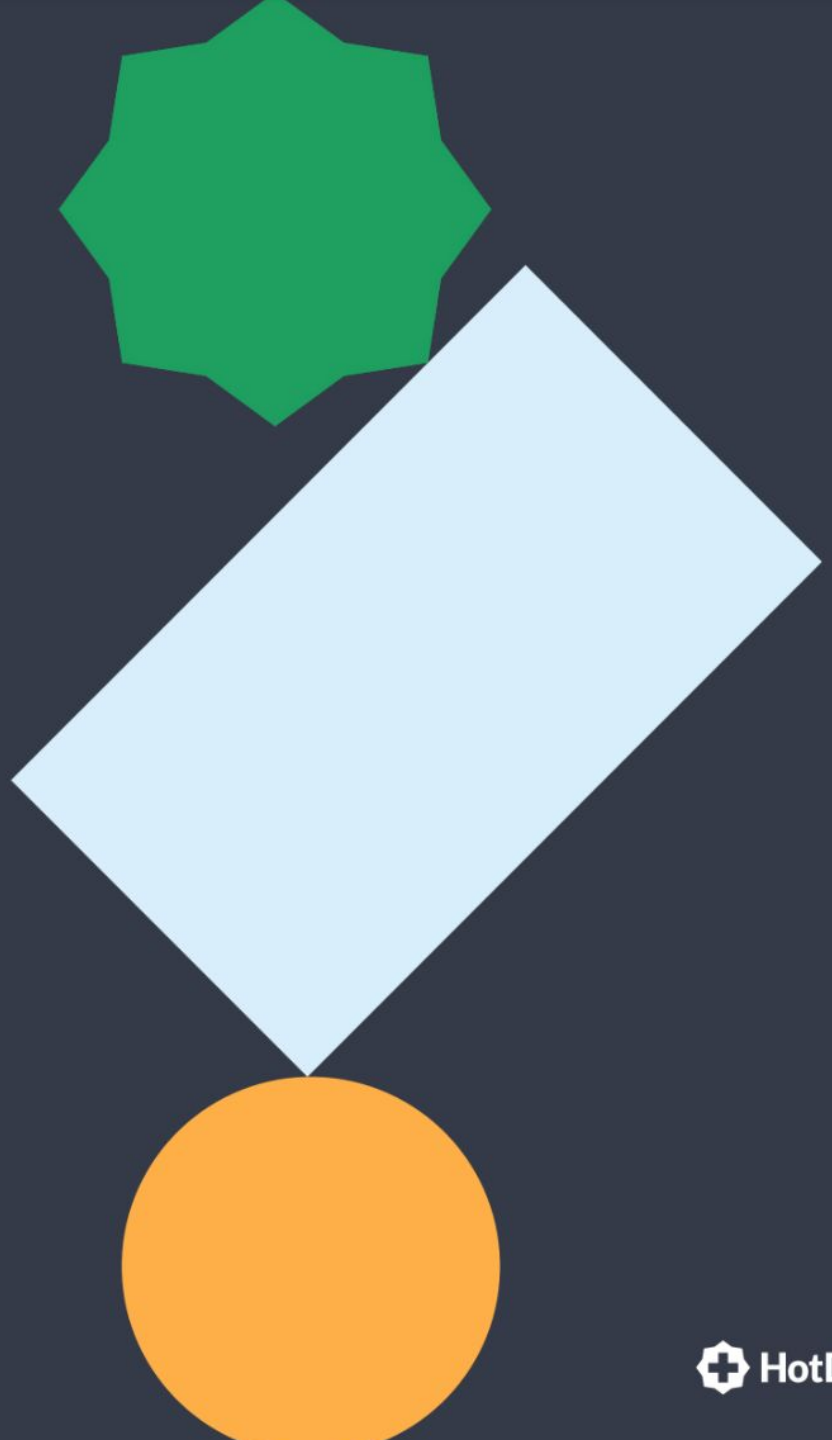
Thank you for watching



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