Quality Improvement Activity

Strengthening Medicare
Chronic Condition Management

General Practice

COORDINARE

phn
SOUTH EASTERN NSW
An Australian Government Initiative

Quality Improvement Activity

Strengthening Medicare - Chronic Condition Management

From July 1 2025, MBS items will be changing to support continuity of care by requiring patients who are registered in MyMedicare to access chronic disease management plans through the practice where they are registered.

Practices are encouraged to register for MyMedicare, and to assist patients with chronic conditions or existing care plans to register for MyMedicare.

Use this Quality Improvement Activity as a guide to plan your practice implementation of MyMedicare and a supported approach to patients with an existing care plan or chronic condition.

Supporting Patients with MyMedicare Registration

For more information on the changes and updated framework visit the Department of Health and Aged Care website.

Patients with complex health conditions may benefit from improved continuity of care that comes with MyMedicare registration. To prepare your practice consider a supported approach to MyMedicare registration for the following groups:

- Patients who are eligible for chronic condition management planning or review
- Patients with chronic conditions
- Patients who have had a care plan billed in the previous 12 months
- Patients with upcoming appointments.

Registration of your MyMedicare patients should be a gradual process, start with your cohorts who will benefit from enrolment right now. You can also filter by doctor, condition, or age for a more manageable sized list.

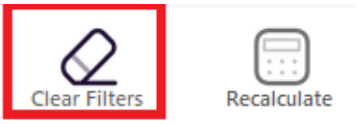
Getting started

All searches in this activity use PenCS CAT4 (CAT4) which is available to practices participating in COORDINARE's Sentinel Practices Data Sourcing (SPDS) project.

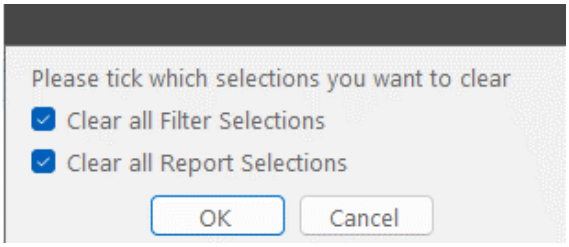
Clean data ensures that the information you are working with is correct and reliable. For detailed data cleansing instructions refer to your SPDS Data Cleansing Manual (Blue Manual). This should be completed before starting quality improvement activities. Contact your Health Coordination Consultant to register for SPDS or if you or your team require training in CAT4 or data cleansing.

Clearing filters between searches

1. After each search you will need to clear filters. Click Clear Filters (top right-hand corner).



2. Ensure both boxes are selected and select OK.



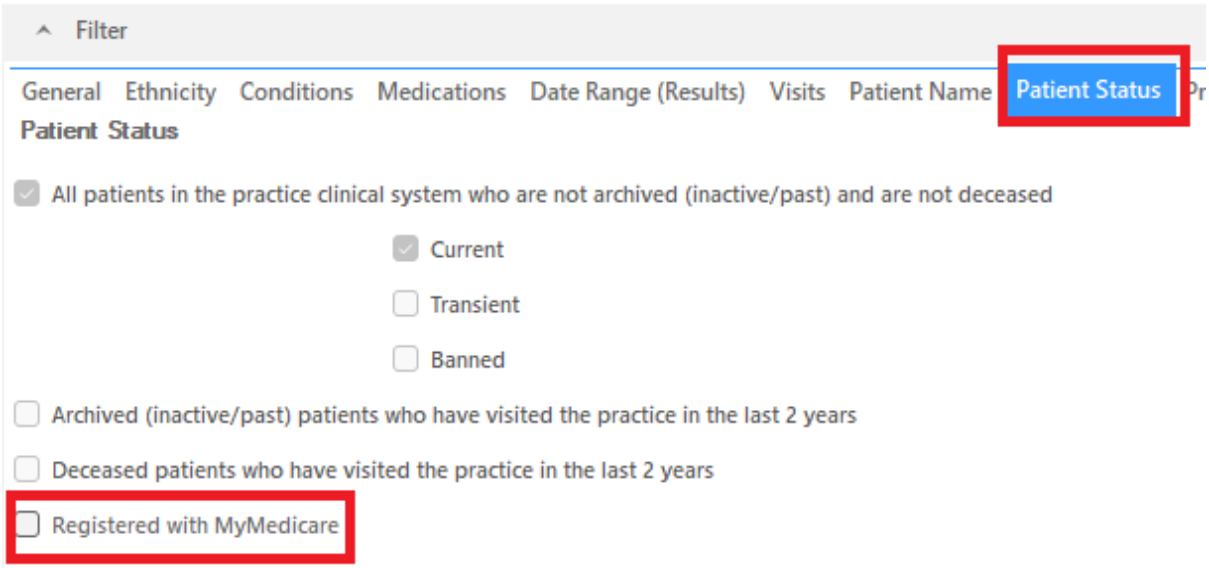
3. Then click recalculate.

4. Now you are ready to run your next search.

MyMedicare registration filter

For each of the searches included in this guide ensure that the registered with MyMedicare box is unticked. This will ensure your search only displays patients that are not already registered for MyMedicare so long as you have added them to your medical software.

You will need to do this step before every search as clearing filters will return your search to your whole patient population.

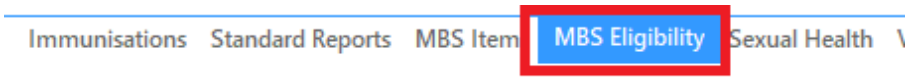


Step 1 - Use data to identify patients

Patients who are eligible for chronic disease management planning or review

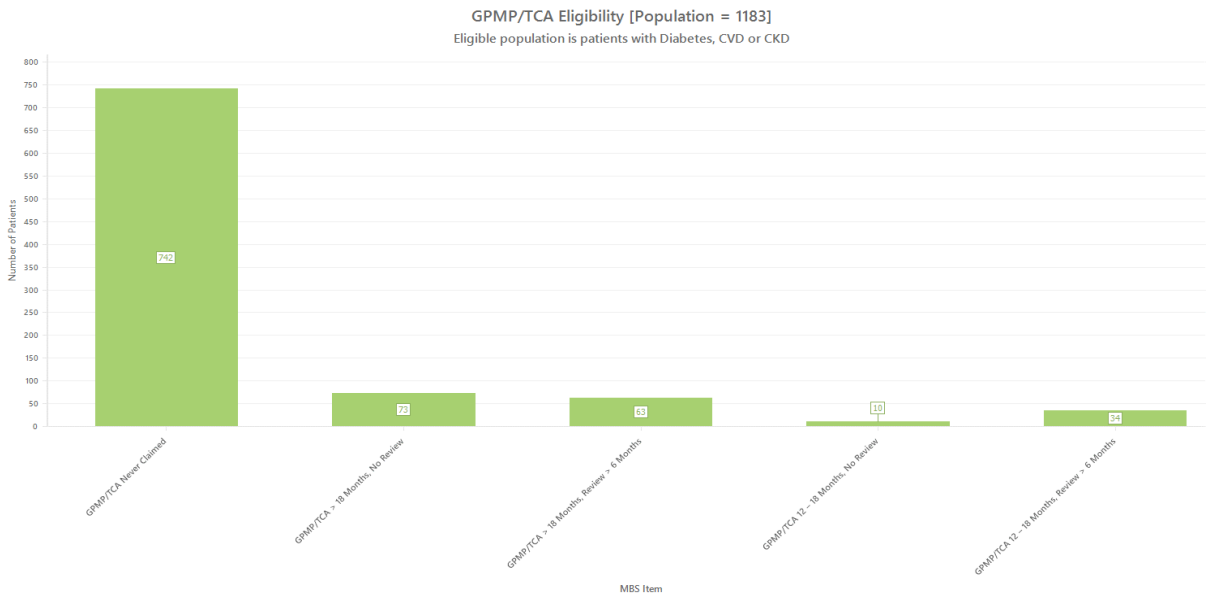
This CAT 4 report shows patients with diabetes, chronic vascular disease or chronic kidney disease who are eligible for GPMP/TCA.

1. Identify patients who are eligible and due for a care plan using CAT4.
2. In the **filters section** go to patient status and untick the registered with MyMedicare box and then recalculate.
3. In the **reports section** click on MBS Eligibility tab.



Keeping in mind that CAT4 can only pull data from your practice software, remember to cross check patient eligibility with PRODA as patients may have had services completed at another provider.

4. Double click on any of the green bars in the **report section** to bring up the patient list.



5. The report can be broken down into:
    - GPMP/TCA never claimed
    - GPMP/TCA > 18 months, No review
    - GPMP/TCA > 18 months, review > 6 months
    - GPMP/TCA 12-18 months, no review
    - GPMP/TCA 12-18 months, review > 6 months
6. Consider focusing on one group at a time and filtering by doctor, age, or visit date range to narrow the patient list.
7. Clear filters.

Patients with chronic conditions

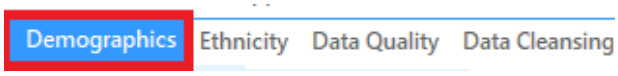
"Patients with one or more medical conditions that have been (or are likely to be) present for at least 6 months, or terminal condition(s). A patient is considered to have complex care needs if they require ongoing care from a multidisciplinary team consisting of their GP or prescribed medical practitioner, and at least 2 other health or care providers."

– Australian Government Department of Health and Aged Care
Medicare Benefits Schedule – Note MN.3.1

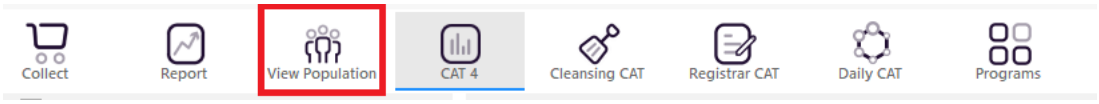
As there are a range of conditions that could fall under this group here are some examples and ideas for identifying these patient cohorts.

COPD

1. In the **filters section** go to patient status and untick the registered with MyMedicare box.
2. In the **filter section** click on conditions.
3. Under Respiratory select COPD then recalculate.
4. Select the demographics report tab.



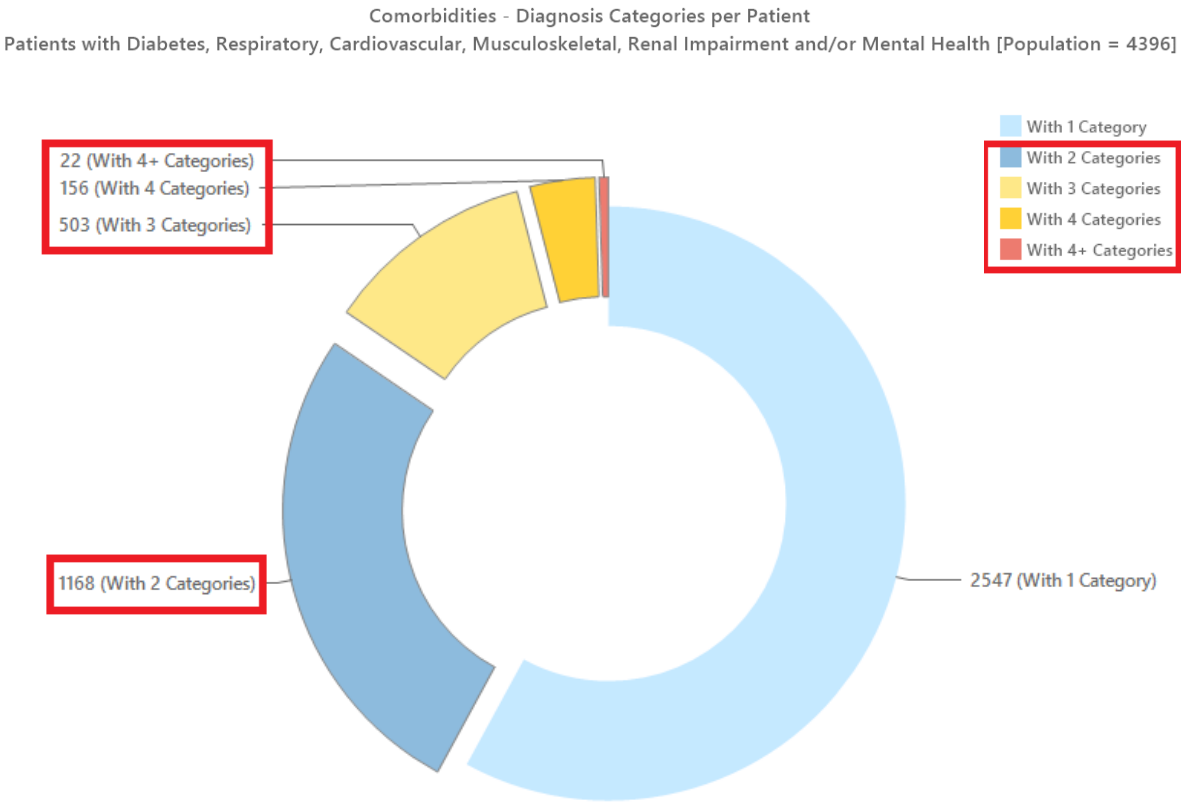
5. Click View Population to bring up the patient list.



Co-morbidities

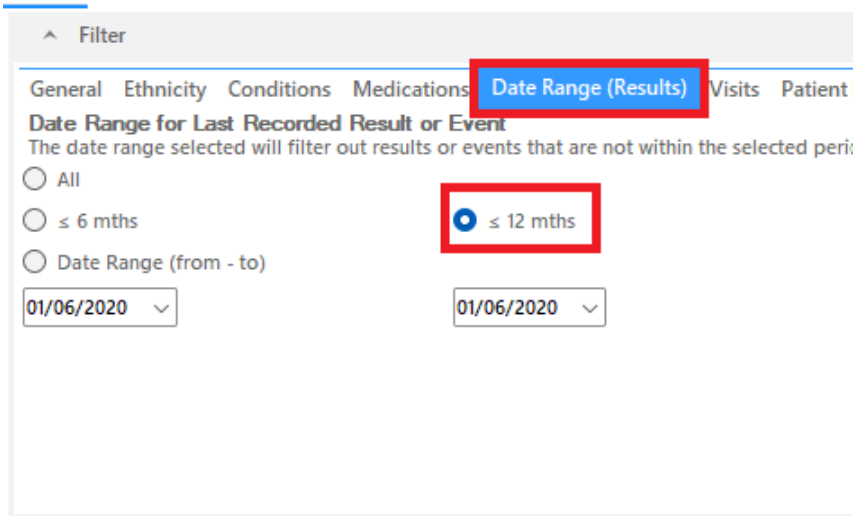
1. In the **filters section** go to patient status and untick the registered with MyMedicare box and then recalculate.
2. In the **report section** click on comorbidities.

3. Select patients who have 2+ categories of comorbidities.
4. Consider focusing on one group at a time and filtering by doctor, age, or visit date range to narrow the patient list.

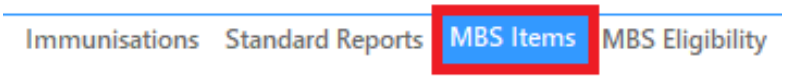


Patients who have had a care plan billed in the past 12 months

1. In the **filters section** go to patient status and untick the registered with MyMedicare box.
2. In the **filter section** click date range results and select ≤12 months then recalculate.



3. In the Reports Section select MBS Items.



4. Double click on the corresponding green bars to bring up the patient list.

Step 2 – Document your quality improvement activity

This quality improvement plan template is taken from COORDINARE's Data Management Tool, for access to the complete tool contact your HCC. An example is provided below of a quality improvement activity and plan. You can complete your own plan on the next page.

Quality Improvement Plan Example

Remember: Use the SMART goal setting framework to write your improvement plan. Ensure your goals are specific (S), measurable (M), achievable (A), realistic (R) and time based (T).

*Achieving improvements requires the **collaborative effort of the entire practice team!***

Measure or Target group	Patients with 4+ categories of comorbidities
Initial baseline What is your baseline?	15.4%
Goal What are we trying to accomplish and when? (Use the **SMART goal** setting framework - **S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**imely)	In the next six months (Time based, realistic), the percentage of active patients with 4+ categories of comorbidities not registered for MyMedicare (specific), will be reduced to 10% or less (measurable and achievable)
Ideas What will you do in the practice to lead to improvement? Brainstorm ideas on how to achieve your **SMART goal**.	1. MyMedicare posters displayed in the waiting room 2. All staff trained in MyMedicare conversations with patients 3. Patients with 4+ categories of comorbidities sent a text message or letter containing information about MyMedicare and the benefits of registration 4. Flagged on the patient file for GP or nurse to have MyMedicare discussion when the patient visits for their next appointment

Quality improvement team Names, responsibilities and roles should be listed. When considering responsibilities and roles, think about collection of data, communicating with team, sharing progress with team, and completing this improvement plan. ***Remember**: You will need to identify who in the team is leading this work.*	**Role**: Practice Nurse **Name**: Ben **Responsibility**: Flag patient files who would benefit from MyMedicare registration. Support patients with registration if required.
	Role: Practice Manager **Name**: Josie **Responsibility**: Ensures all staff are aware of MyMedicare and conversations to have with patients. Send MyMedicare information to the identified group who would benefit from supported MyMedicare registration.
	Role: GP **Name**: Dr Louise **Responsibility**: When flagged patients attend for appointments be prepared to have MyMedicare conversations with patients.

Complete your Quality Improvement Plan

Remember: Use the SMART goal setting framework to write your improvement plan. Ensure your goals are specific (S), measurable (M), achievable (A), realistic (R) and time based (T).

*Achieving improvements requires the **collaborative effort of the entire practice team!***

Measure or Target group	
Initial baseline What is your baseline?	
Goal What are we trying to accomplish and when? (Use the **SMART goal** setting framework - **S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**imely)	
Ideas What will you do in the practice to lead to improvement? Brainstorm ideas on how to achieve your **SMART goal**.	
Quality improvement team Names, responsibilities and roles should be listed. When considering responsibilities and roles, think about collection of data, communicating with team, sharing progress with team, and completing this improvement plan. ***Remember**: You will need to identify who in the team is leading this work.*	

Additional support and information

- MBS Online - Information on the changes to MBS chronic disease management items.
- Visit COORDINARE's MyMedicare Webpage.

Email: info@coordinare.org.au

Phone: 1300 069 002

Contact your local Health Coordination Consultant.

Please note the information contained in this guide was correct at time of publishing.*