The nurse’s contribution to GPCCMP development and patient engagement

13 November 2025

Dr Paresh Dawda

Kylie Foley

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Eastern Melbourne PHN is primarily funded by the Australian Government through the Department of Health and Aged Care

Acknowledgement of Country

Eastern Melbourne PHN acknowledges the Wurundjeri people and other peoples of the Kulin Nation on whose unceded lands our work in the community takes place. We pay our respect to Aboriginal and Torres Strait Islander cultures; and to Elders past and present. EMPHN is committed to the healing of country, working towards equity in health outcomes, and the ongoing journey of reconciliation.

Recognition of lived experience

We recognise and value the knowledge and wisdom of people with lived experience, their supporters and the practitioners who work with them and celebrate their strength and resilience in facing the challenges associated with recovery. We acknowledge the important contribution that they make to the development and delivery of health and community services in our catchment.

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Housekeeping Team webinar

All attendees are muted

Be mindful not to use any patient identifying information during your participation

Please ask questions via the Chat box only

Questions will be answered at the end of the presentation

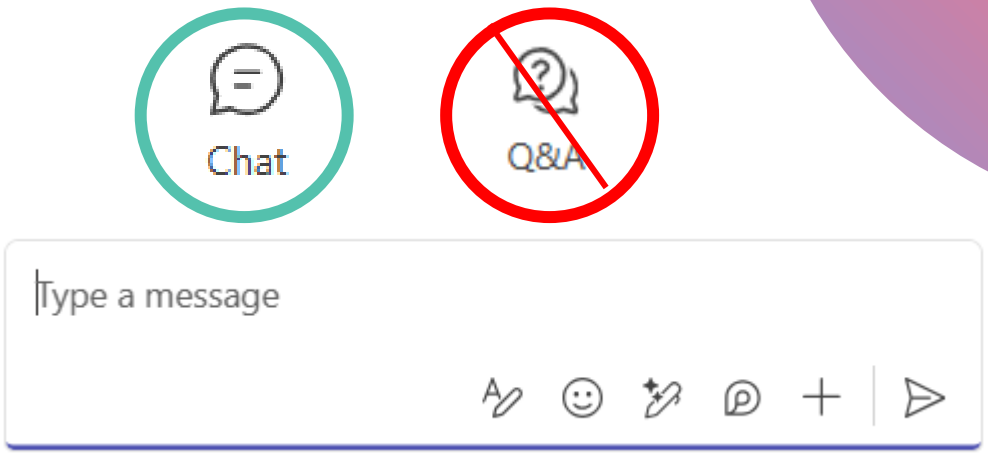
This session is being recorded

All attendees will receive a link to this recording and copy of slides in post session correspondence.

Please Do Not

Please DO NOT use:

- Q& A section
- AI notes transcription as this is a distraction to the presenter



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Agenda

- Strengthening Medicare: The Why and What of CCM Reform
- A Practice in Action – Case Study
- Making it work in your practice: Tips and Tools
- Q&A and Reflections

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Speakers

Dr Paresh Dawda - Principal General Practitioner and Director, Prestantia Health

https://deakin.nextpracticehealth.com and https://www.prestantiahealth.com

Kylie Foley -Practice Nurse and Diabetes Educator, Hills Family General Practice

https://hillsfamilygeneralpractice.com

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GP Chronic Condition Management Plans

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Why is chronic condition management important?

50% of All Australians are living with at least 1 of the 8 chronic conditions reported by AIHW

In 2022, 55% of all hospitalisations were related to a chronic condition

Primary care/general practice is crucial in the management of chronic conditions

Two fundamental questions!

Do care plans make a difference?

What are the components of care plan that make the difference?

General practice activity and care planning makes a difference

Source: https://www.health.nsw.gov.au/lumos/Factsheets/diabetes-early-gp.pdf

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Management of Diabetes in the Community Influences for Acute Care and Mortality

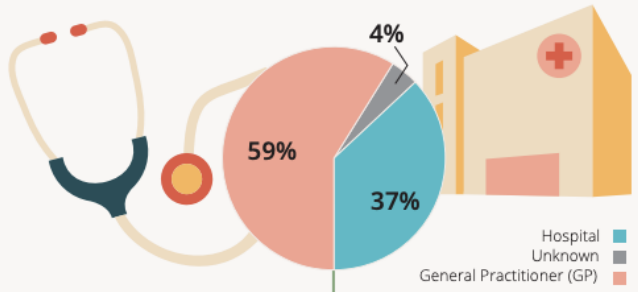
Impact of Diabetes Managed Early in General Practice

Emerging evidence suggests that detecting and managing diabetes in the general practice setting is associated with a lower risk of unplanned admissions to hospital. This highlights the importance of coordination between and continuity of care across the primary and acute care settings. Here we compare people over two years with diabetes that was first recorded in a general practice setting with those with diabetes that was first recorded in a hospital record.

Findings

Where diabetes diagnosis was first recorded

Diabetes diagnosis was much more commonly first recorded in the GP record

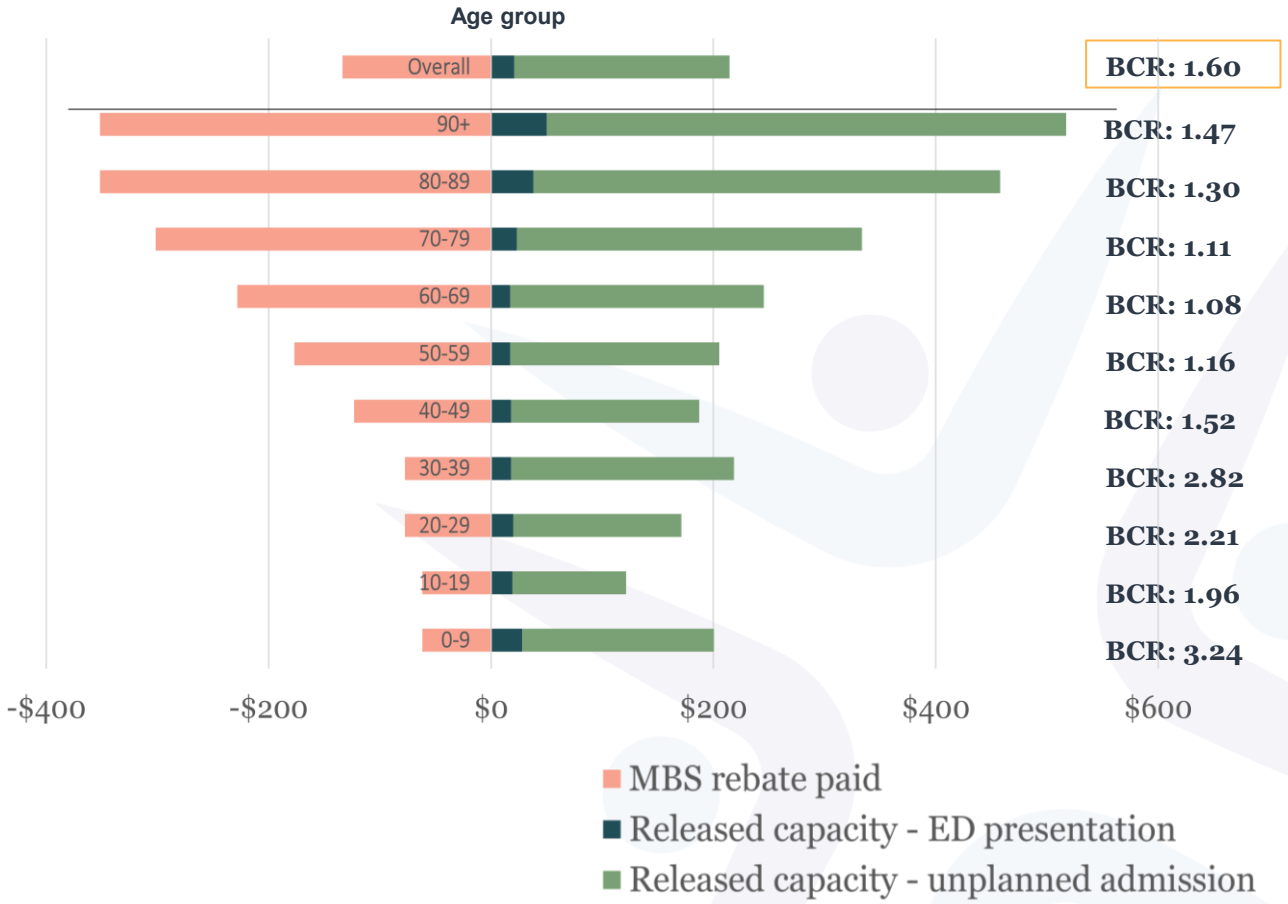


	People with diagnosis first recorded at the GP	People with diagnosis first recorded in hospital
Where diabetes diagnosis is first recorded varies by people's characteristics, such as remoteness of residence	Over half in cities or regional centres.	Up to two thirds living in remote and very remote area.
Proactive care in the community was more common for people who had their first recorded diabetes diagnosis in the GP record	Over the 2-year study: 50% have antidiabetic medications prescribed. More likely to have GP management plans and reviews. More likely to have blood pressure, cholesterol and HbA1c recorded.	Over the 2-years, 27% have antidiabetic medications prescribed.
Presentation to hospital was less common among people who had their first recorded diabetes diagnosis in the GP record	Over the 2-year study: • 16 GP visits • 2 ED presentations • 2 Hospital admissions • 8 Outpatient services.	Over the 2-year study: • 10 GP visits • 2 ED presentations • 4 Hospital admissions • 12 Outpatient services.
Mortality was lower for people who had their first reported diagnosis in the GP record	4% mortality across the study period.	6% mortality across the study period.

Continuity of care makes a difference

Benefit cost ratio (BCR) of a patient being serviced by a high connectivity practice compared to a lower.

Overall: $1.60 healthcare system benefits for every $1 spent in the primary care system



Source: www.health.nsw.gov.au/Lumos

Care Plan Components and Supporting Evidence

Care Plan Component	Description	Evidence/Source
Patient-centred goals	Goals in patient's own words reflecting their values	Coulter et al. (2015) BMJ
Comprehensive assessment	Current diagnoses and clinical issues	MBS Review Taskforce (2020)
Functional and psychosocial assessment	ADLs, mental health, social needs	Bodenheimer et al. (2002)
Medication reconciliation and review	Current meds, adherence, side effects	NPS MedicineWise, HMR outcomes
Lifestyle assessment and interventions	Smoking, diet, activity, alcohol	NICE Guidelines (2020)
Self-management support	Education and skill-building for self-care	Wagner's Chronic Care Model
Coordination of team-based care	Roles, referrals, integrated care team	Ham et al. (2012)
Review and follow-up schedule	Planned intervals and escalation plan	RACGP Standards (2020), MBS GPCCMP
Documentation and information sharing	With patient and team, MyHR	ADHA (2022), HealthPathways
Consent and activation	Informed patient agreement	RACGP Standards (5th edition)

Why the changes?

- The MBS Taskforce deliberations:
  - Strong support for a reduction in red tape
  - About half of patients with a care plan never have a review (732) billed
- Recommendations:
  - Replace 721 and 723 with one item
  - Enable allied heath referral with a care plan
  - Remove red tape
  - Link care plans with enrolment to encourage continuity of care

(https://www.health.gov.au/sites/default/files/documents/2020/12/taskforce-final-report-primary-care-report-on-primary-care.pdf)

Strengthening Medicare Taskforce

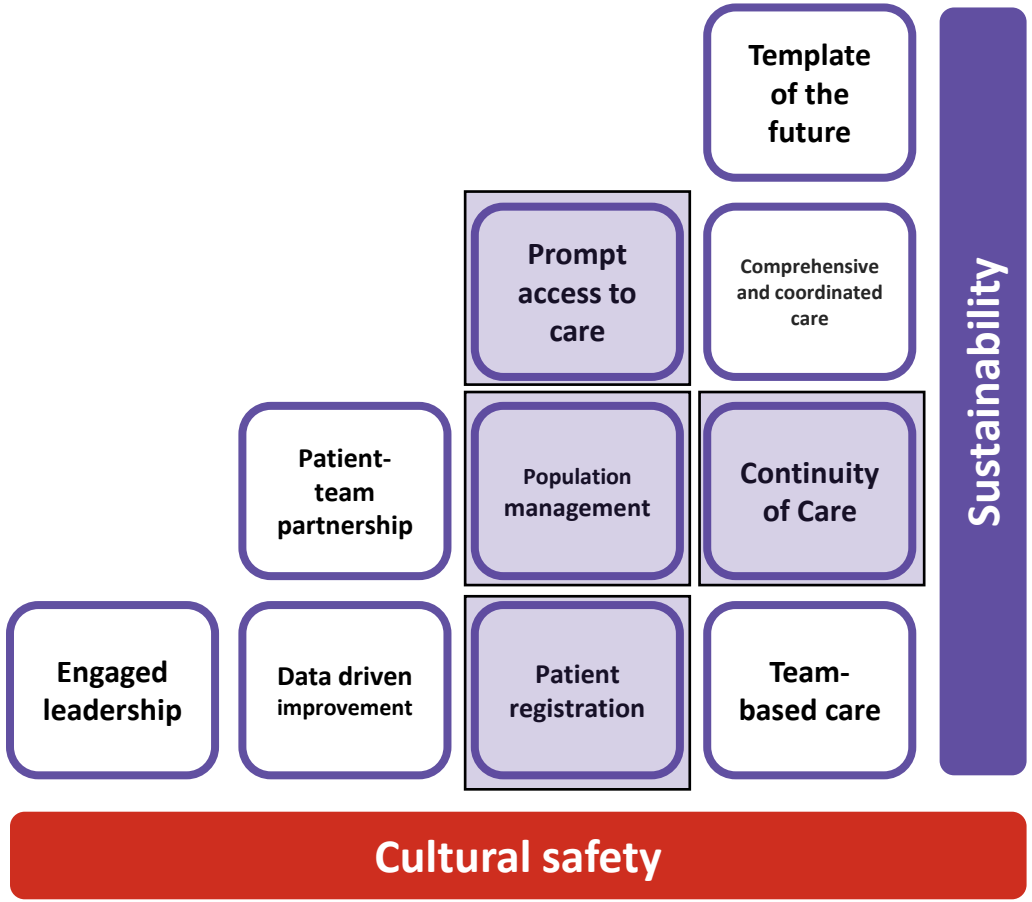
Increasing access to primary care

Encouraging multidisciplinary team-based care

Modernising primary care

Supporting change management and cultural change

My Medicare



Reform

- patient registration from 1 Oct 2023
- enables longer Level C/D telephone consults for registered patients from 1 Nov 2023
- expanding incentives

What changed?

patient–practice registration

unlocks benefits tied to the patient's **registered usual practice**.

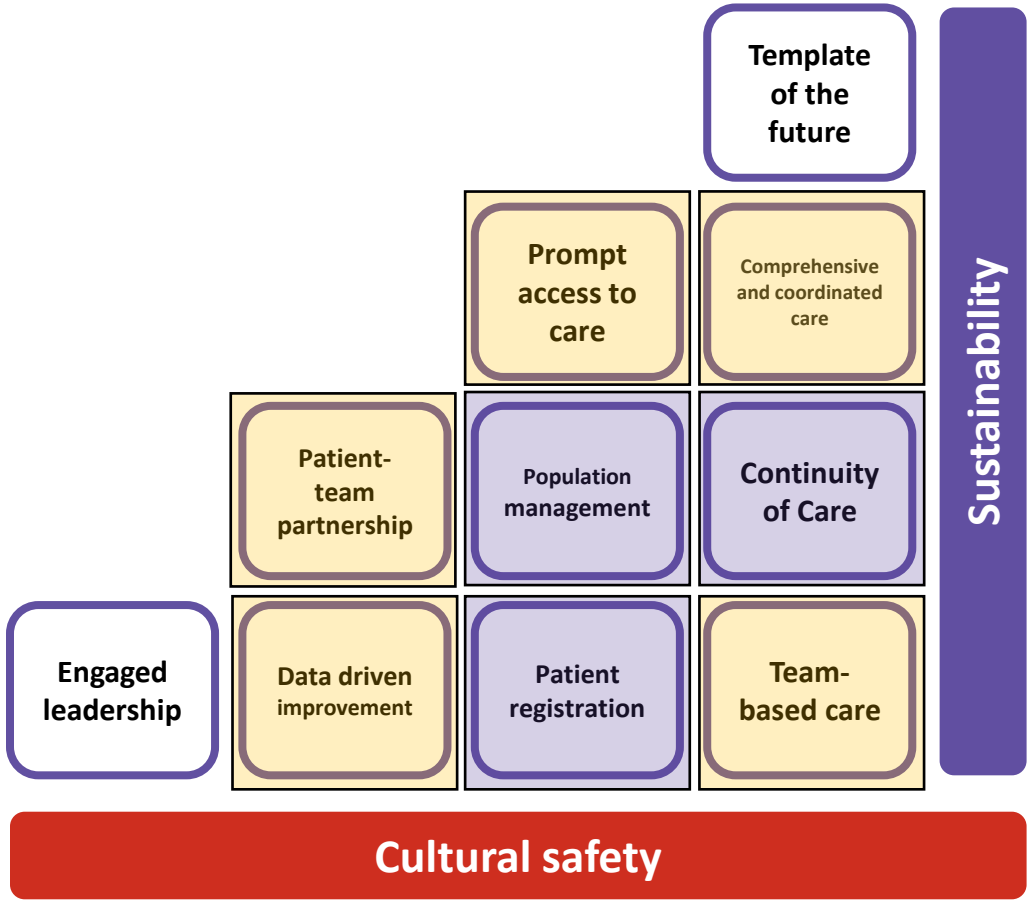
Why it maps?

Empanelment underpins continuity and population health

telehealth benefits and future incentives are contingent on registration with a usual GP/practice.

Adapted: Bodenheimer T, Ghorob A, Willard-Grace R et al. The 10 building blocks of high-performing primary care. Annals of Family Medicine 2014.

GPCCMP



Reform

- from 1 July 2025

What changed?

Withdrawal of Medicare Benefits Schedule (MBS) items for General Practitioner Management Plans (GPMPs) and Team Care Arrangements (TCAs)

Replaced with a new streamlined GP Chronic Condition Management Plan (GPCCMP).

Why it maps?

GPCCMP underpins continuity and population health

Potential to enhance;

- patient-team partnership and team-based care
- Inform prompt access to care and enable comprehensive and coordinated care
- patient safety and quality improvement – focus on outcomes

Adapted: Bodenheimer T, Ghorob A, Willard-Grace R et al. The 10 building blocks of high-performing primary care. Annals of Family Medicine 2014.

What are the changes

Aspect	Current (pre-1 July 2025)	Future (from 1 July 2025)
Planning Items	GPMPs (Items 229, 721, 92024, 92055), TCAs (230, 723, 92025, 92056)	GPCCMPs: Single plan system (Items 965, 392, 92029, 92060)
Review Items	Separate TCA/GPMP reviews (Items 233, 732, 92028, 92059)	Unified review (Items 967, 393, 92030, 92061)
Fee Structure	Varied: e.g. GPMP $164.35, TCA $130.25, Review $82.10	Standardised: $156.55 for GPs, $125.30 for PMPs
Referral Requirements	Formal referral forms required; two collaborating providers for TCA	Referral letters only; no requirement for multiple collaborators
Allied Health Access	Up to 5 individual + group services via TCA	Same access but under GPCCMP; valid for 18 months from first service
Transition Arrangements	Current plans valid until 30 June 2027	Post-1 July 2027, GPCCMP mandatory for access
Support Roles	Assistance by practice nurses, Aboriginal health workers (within TCA)	Same support roles, also assist with GPCCMP
Eligibility	Chronic condition ≥6 months or terminal illness	Same eligibility, clinical discretion remains
MyMedicare Requirement	Not required	Mandatory use of enrolled practice for MyMedicare patients

Changes to the CCM Framework

Chronic Condition: At least **one** medical condition that has been (or is likely to be) present for at least 6 months, or is terminal

- To **support patients** that would benefit from a **structured** approach to their care.
- Available **whether or not** the patient need allied health
- **Intent of the policy**: to encourage continuity of care; team base care; regular reviews.
- Supporting a change from a **"static"** to a **"live document"**

Linking with My Medicare

- A patient who is not registered can have a care plan by their “usual doctor”
- A patient who is registered can only have their care plan done at the practice in which they are registered
- A doctor that attempts to bill a care plan on a patient registered elsewhere will have payment rejected
- How many of your patients have you registered?
- Do you know how to check your patients’ registration status?

** usual doctor is defined as the GP/practice who has provided the majority of the care in the previous 12 months and/or who will be provide the majority of the care in the next 12 months

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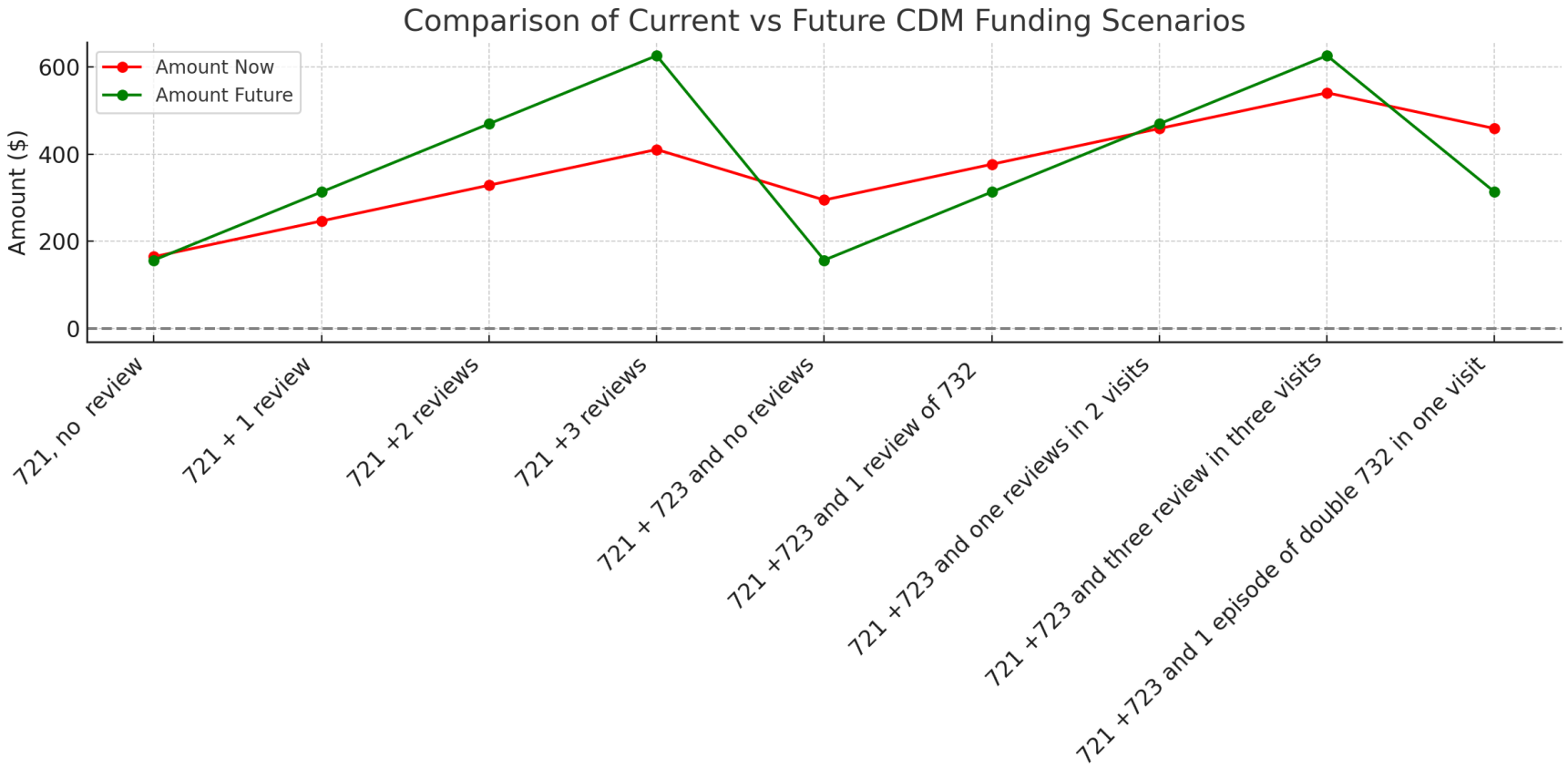
The finances…

- Think about what you do now and the weighting of reviews to care plans and TCA
- Not every patient needs a TCA and not every patient needs a double review
- What is the value of time wasted with red tape? GP time? Nurse time? Admin time?
- How many more patients can you all serve in that wasted time?
- How do you use your team to improve care and use wasted time better?
- Don’t forget TH (video)



Transition arrangements

Patients who a on a care plan/TCA before 1 July can still access their 5 allied health visits and 10997 until 30 June 2027

Anyone with a new care plan or care plan review from 1 July can use allied health for 18 months (5 visits)

From 1 July 2027, only patients with a 965/967 will be able to have medication reviews

From 1 July 2025:

Any new plans put in place will need to meet the requirements of a GPCCMP

Any new referrals for allied health services should meet the new referral requirements that come into effect on 1 July 2025, regardless of whether the referral is made under a GPMP, TCA or GPCCMP.

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The GPCCMP process and role of the nurse

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Hills Family Practice Case Study 1

- 58 year old female
- History of diabetes and recent cholangiocarcinoma (10/2024)- still currently having treatment
- Colitis 8/2025 requiring steroid treatment, causing hyperglycemia needing insulin
- Insulin start with remote monitoring
- Care plan 3/12 + 10977

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Hills Family Practice Case Study 2

- 93year old female
- Department of Veterans' Affairs patient
- Past medical history of heart failure, kidney disease and hypertension
- Care plan/DVA UP03 + 1/12 check ins either face-to-face or by phone

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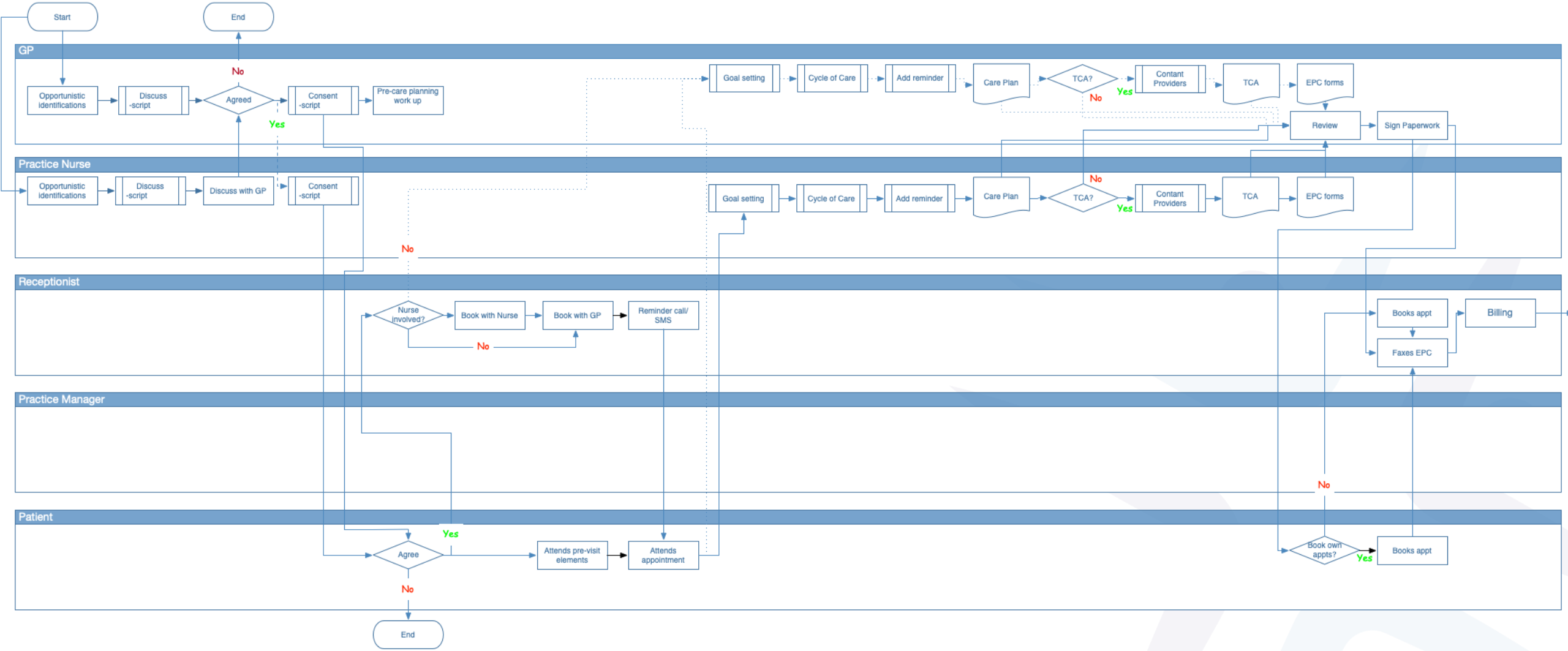
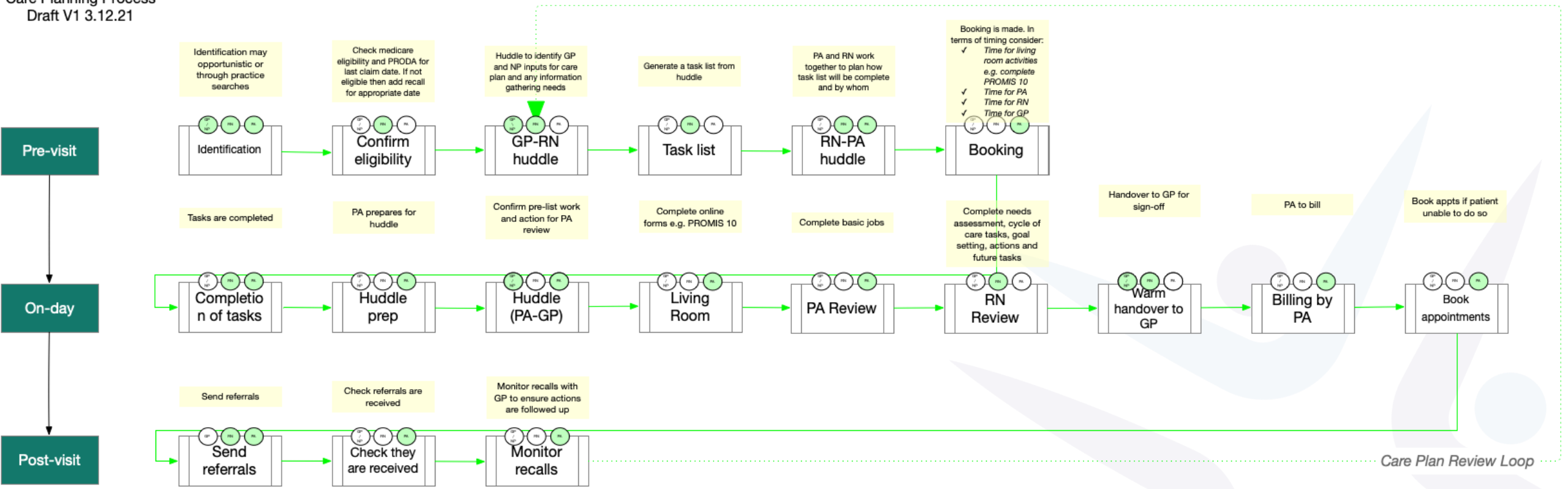
Current State New Care Plan Process



Care Planning Process
Draft V1 3.12.21



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Quality chronic condition management plans

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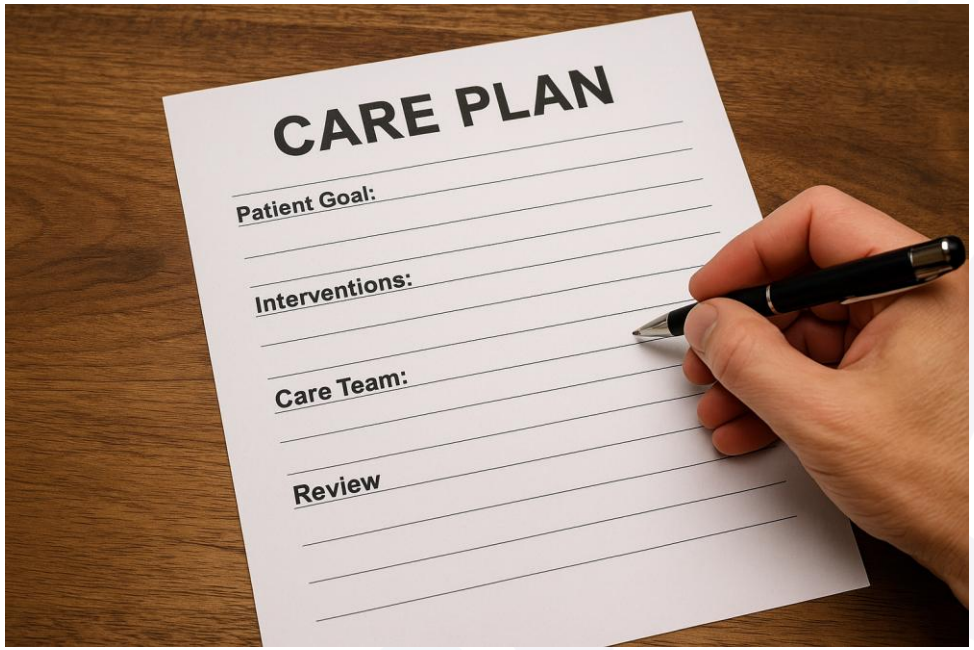
What needs to be in a care plan?

- Preparing a GPCCMP will be defined as preparing a written plan which describes:
  - The patient's chronic condition(s) and associated health care needs
  - Health and lifestyle goals developed by the patient and medical practitioner using a shared decision-making approach;
  - Actions to be taken by the patient
  - Treatment and services the patient is likely to need if the patient would benefit from multidisciplinary care to manage the chronic condition(s) the services that the medical practitioner will refer the patient to (including the purposes of those treatments or services)
  - Arrangements to review the plan, including the proposed timeframe for review (3 months allowed)
  - Need patient consent
  - Need to offer to the patient
  - "Encouraged" to upload to the MHR
  - **Check the MBS descriptor and explanatory notes**



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From individual to population-based management approach

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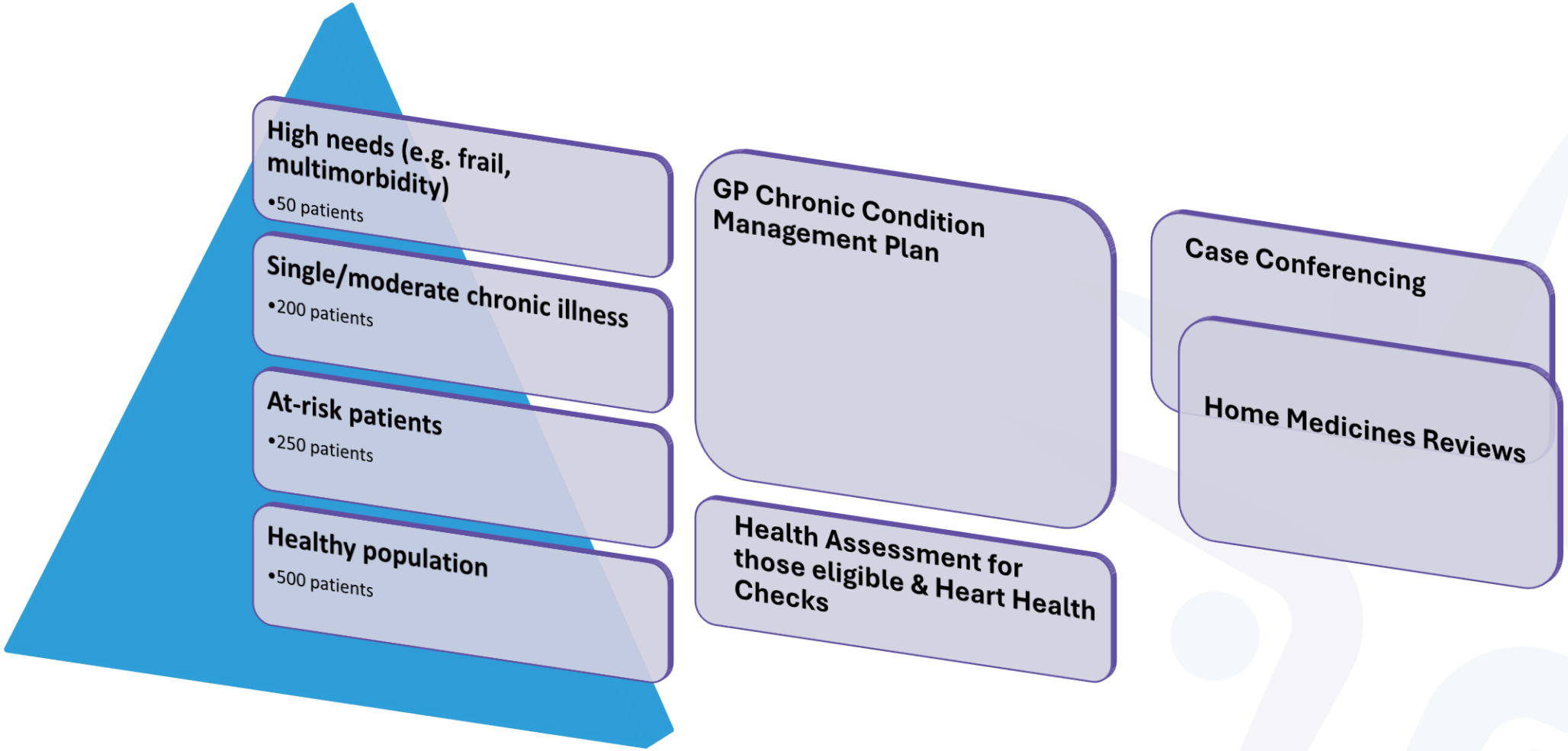
The Population Health Pyramid



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From individual to population-based management

Patient	Month of next follow-up	Email address	MyMedicare	Details for next visit/ Actions?	Follow up plan
	December-24		Y		emailed to reception again to call in june
	December-24		Y		emailed to reception again to call in june
	January-25		Y		emailed to reception again to call in june
	February-25		Y		emailed to reception again to call in june
	February-25		Y		pt advised to book 14/4/25, another email at rec to chase
	February-25		Y		Booked June 25
	March-25		Y		seeing Daris now?
	March-25		Y		WJ to action/review file
	March-25		Y		file inactive?
	March-25		Y		WJ to action/review file
	March-25		Y		WJ to write up form, TS to call
	March-25		Y		Booked for GPMP Aug
	March-25		Y		file inactive?
	March-25		Y		Move to Emma's list
	March-25		Y	watch bsl urine and K	WJ to review file

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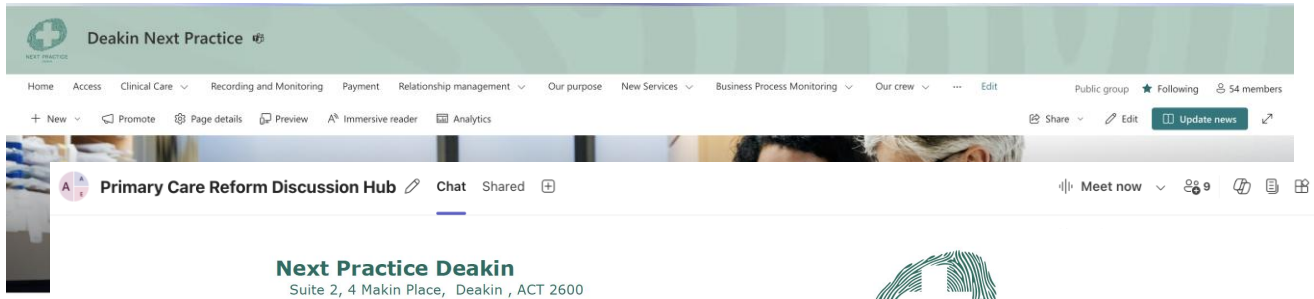
What we have done @ NPD so far

- SharePoint page for people living with chronic conditions and person-centred care
- MS Team chat to specifically discuss all things reform
- Monthly meetings to discuss reform until end of year on top of fortnightly operational/clinical meetings
- Recalls created (GPCCMP and GPCCMP Review)
- Template created
- Internal training plan being rolled out



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Care Plan

Mx Testing Deakin	20/08/1936 (88 years)
80 Wentworth Avenue Surry HillsNSW2010 E: amy.sinclair+deakin@nextpracticehealth.com T:(02) 6185 5555 M:0450 416 350 Medicare: 2222 22220 0 /2 Exp: 28-02-2027 DVA: Exp:	NOK: ( ) Carer: T: E: MyMedicare Status: Registered/Not Registered
Power of Attorney:	
Advanced Health Directive:	
Consent to Care Plan	Yes
Date of GPCCMP	14 June 2025
Prepared by	Prof Paresh Dawda

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Checklist

🗂️ Clinical and Operational Readiness

- **Audit existing care plans** to identify patients who will need to transition to GPCCMPs after 1 July 2025.
- **Update recall and reminder systems** to flag reviews due within 18 months to maintain allied health access.
- **Configure clinical software** to:
  - Use new item numbers (965, 967, etc.)
  - Support referral letter templates (rather than forms)
  - Track MBS billing limits (12-month for plans, 3-month for reviews)

👩‍⚕️ Staff Training and Protocols

- **Educate GPs** on:
  - New eligibility criteria
  - Shared decision-making for setting goals
  - Referrals using letters instead of forms
- **Train nurses and Aboriginal health workers** to assist with plan preparation and reviews under supervision.
- **Review scope of practice** for each team member to ensure delegation and documentation are compliant.

📋 Billing and MBS Compliance

- **Incorporate new GPCCMP MBS item numbers**:
  - Plan preparation: 965 (GP), 392 (PMP), 92029/92060 (telehealth)
  - Plan review: 967 (GP), 393 (PMP), 92030/92061 (telehealth)
- **Update billing policy** to avoid co-claiming with standard attendance items on the same day.

📝 Patient Communication and Engagement

- **Inform patients** (via SMS, email or handouts) about the changes and the importance of care plan reviews.
- **Encourage MyMedicare registration** to facilitate coordinated care and eligibility tracking.
- **Prepare patient-friendly goal-setting worksheets** or digital forms to support shared decision-making.

💻 IT and Documentation Tools

- **Set up referral letter templates** aligned with new MBS requirements (no mandatory service count or provider name).
- **Enable My Health Record uploads** for GPCCMPs, with patient consent.
- **Review and update privacy and consent procedures** for sharing care plans with allied health professionals.

📊 Quality Improvement & Reporting

- **Incorporate care plan reviews and referrals into quality improvement cycles** (e.g. PDSA).
- **Use PHN or software tools to track CDM metrics**, such as active care plans, review rates, and allied health referrals.
- **Participate in peer review or clinical governance activities** to ensure consistency and quality in care planning.

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Summary of enablers

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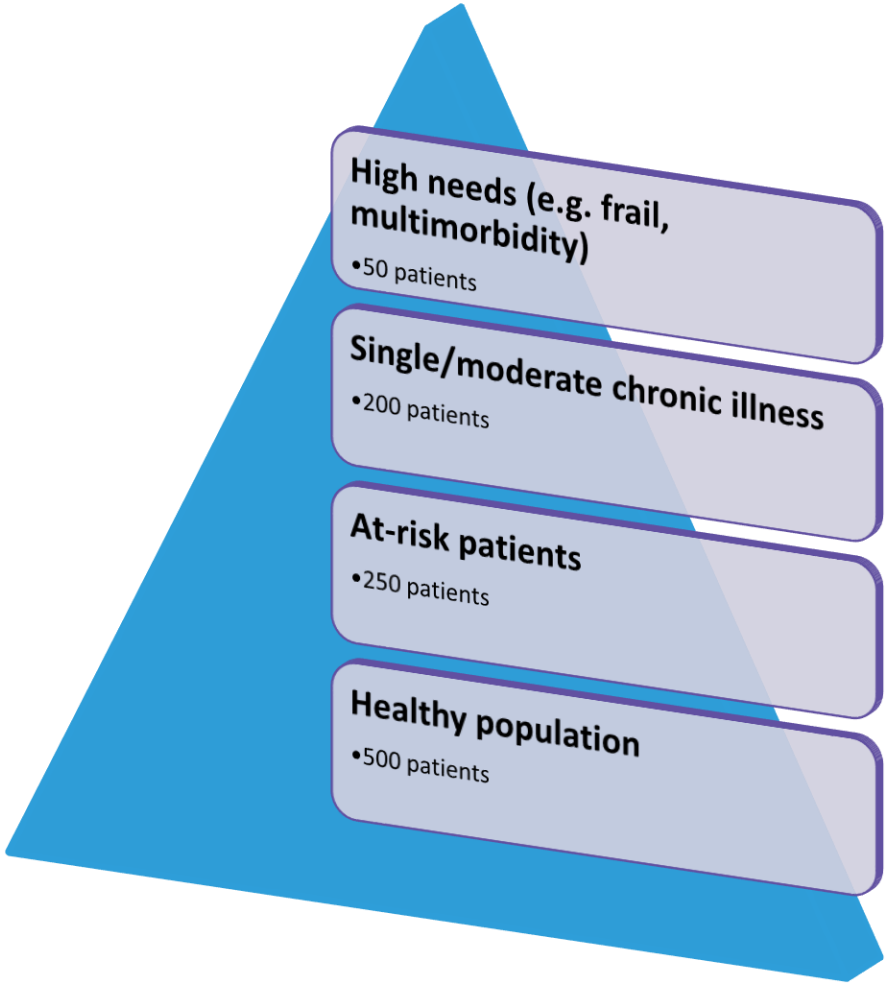
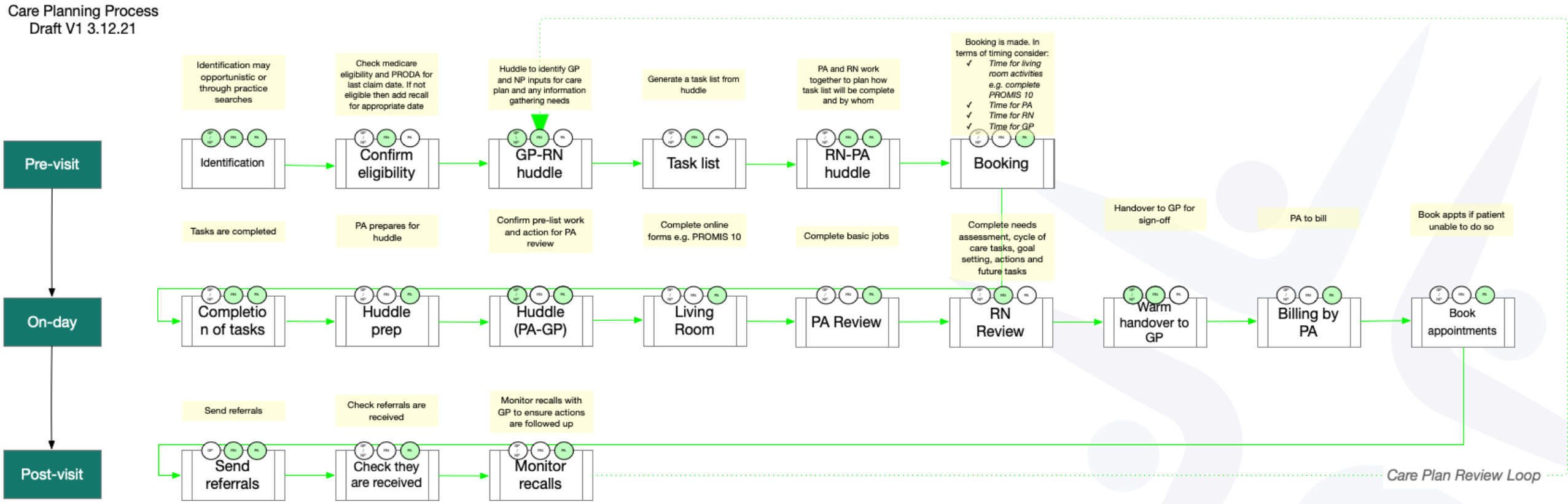
Key enablers: Patient registers



Patient registers:

- By complexity/need
- By usual GP

Key enablers:
Patient journey, workflow, process map



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Key enablers:
Standing orders - Delegations to nursing staff

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Title: Standing order for initiating FOB screening for eligible patients

Policy type: Clinical and Referral pathways

Effective date: 19 November 2018 – reviewed wj -9-7-2023

Authorised by: Walid Jammal

Purpose: Colon cancer screening is an evidence based preventative active. FOB testing is the most cost effective way of screening, with a negative predictive value of 98%. Only about 10% of the population currently comply with the government screening programme. In order to facilitate timely referral and attendance for this examination, nurses and medical practice assistants are authorised to initiate discussion and referral for this test.

Personnel: Nurses, Medical Practice Assistants (MPAs)

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Title: Standing order-nurses giving immunisations

Policy type: clinical

Effective date: 1 July 2017 ; reviewed 26.4.19mj;29.4.21; 9-7-2023-wj;
Authorised by: Walid Jammal

Purpose: Whether it be for nurse led flu vaccine clinics, to childhood immunisations, to travel vaccines ordered by a GP, nurses are well positioned to deliver routine evidenced based vaccinations to patients with little or no GP input.

Personnel: Registered Nurses

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Title: Standing order-ear syringing

Policy type: clinical

Effective date: 1 November 2018 - reviewed wj 9-7-2023
Authorised by: Walid Jammal

Purpose: Ear wax can be very distressing for patients and is one of the most common causes of decreased hearing in adults. The task of ear syringing of wax can be competently done by nurses after a period of observation and in-house credentialing.

Personnel: Registered Nurses

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Title: Standing order for initiating optometrist referral for a patient with diabetes

Policy type: Clinical and Referral pathways

Effective date: 1 July 2017 updated wj -9-7-2023

Authorised by: Walid Jammal

Purpose: Diabetic retinopathy is a known complication of diabetes. Screening for diabetic retinopathy with dilated funduscopic retinal examination and/or retinal images forms part of established and widespread guidelines. It is best detected by careful retinal examination by an optometrist or ophthalmologist. In order to facilitate timely referral and attendance for this examination, nurses and medical practice assistants are authorised to initiate referral for patients as well as facilitate appointments.

Personnel: Nurses, Medical Practice Assistants (MPAs)

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Title: Standing order for initiating of ECGs by practice nurses

Policy type: Clinical and Referral pathways

Effective date: 19 March 2021 reviewed wj 9-7-2023

Authorised by: Daris Vilkins and Farnaz Sardari

Purpose: This protocol outlines appropriate initiation of an ECG on patients prior to review or a request by a GP. The ECG would be performed by another trained professional in the practice such as nurses or MPAs

Personnel: Nurses, Medical Practice Assistants (MPAs)

Policy: Standing orders are approved by the medical staff and practice manager and do not require clinical decisions that are outside the legal scope of practice for a nurse or any other clinical staff who would implement them. An approved standing order authorizes practice staff to initiate the order's pre-defined clinical activities.

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Key enablers: Standardised templates and tools

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	Carer: T: E:
	MyMedicare Status: Registered/Not Registered
Power of Attorney:	
Advanced Health Directive:	
Consent to Care Plan	Yes
Date of GPCCMP	14 June 2025
Prepared by	Prof Paresh Dawda

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Key enablers: Standardised checklist(s)

Key enablers: CIS and analytical tools

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Factsheet	PDF and Word versions
Upcoming Changes to Chronic Disease Management Framework – Overview (Last updated: **22 May 2025**)	Word Version - Upcoming Changes to Chronic Disease Management Framework - Overview.DOCX PDF Version - Upcoming Changes to Chronic Disease Man
Upcoming Changes to Chronic Disease Management MBS Items – Transition Arrangements for Existing Patients (Last updated: **22 May 2025**)	Word Version - Upcoming Changes to Chronic Disease M Arrangements for Existing Patie PDF Version - Upcoming Changes to Chronic Disease M Arrangements for Existing Patie
Upcoming Changes to Chronic Disease Management Framework – Referral Arrangements for Allied Health Services (Last updated: **22 May 2025**)	Word Version - Upcoming Changes to Chronic Disease M Arrangements for Allied Health Ser PDF Version - Upcoming Changes to Chronic Disease M Arrangements for Allied Health Se
Upcoming Changes to Chronic Disease Management Framework – MBS Items for GP Chronic Condition Management Plans (Last updated: **22 May 2025**)	Word Version - Upcoming Changes to Chronic Disea GPCCMPs.DOCX PDF Version - Upcoming Changes to Chronic Disease Man
Upcoming Changes to Chronic Disease Management Framework - Allied Health Providers (Last updated: **6 June 2025**)	Word Version - Upcoming Changes to Chronic Disease Ma Providers.docx PDF Version - Upcoming changes to chronic disease mar Providers.pdf
Upcoming Changes to Chronic Disease Management Framework - Practice Nurse, Aboriginal Health Workers and Aboriginal and Torres Strait Islander Health Practitioners (Last updated: **6 June 2025**)	Word Version - Upcoming Changes to Chronic Disease Man and Aboriginal and Torres Stra PDF Version - Upcoming changes to chronic disease man Torres Strait Islander health pr

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Billing rules for care plans

GP chronic condition management plans

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Home > Health professionals > Payments and claims > MBS claims > MBS and DVA billing > Billing rules for care plans > GP chronic condition management plans

GP chronic condition management plans

Rules about billing Medicare Benefits Schedule (MBS) items for chronic condition management and how to apply them.

on this page

Learn the relevant item descriptions, fact sheets and explanatory notes on the MBS Online website.

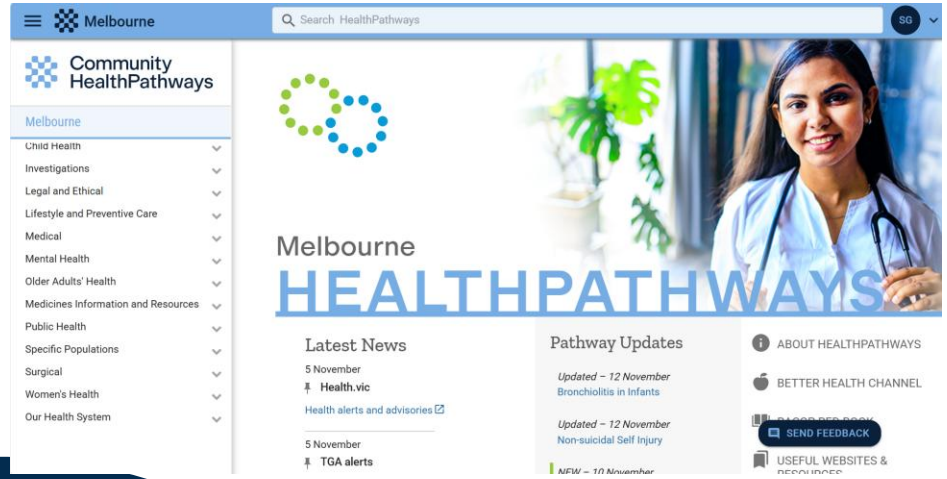
Access the Factsheets Here

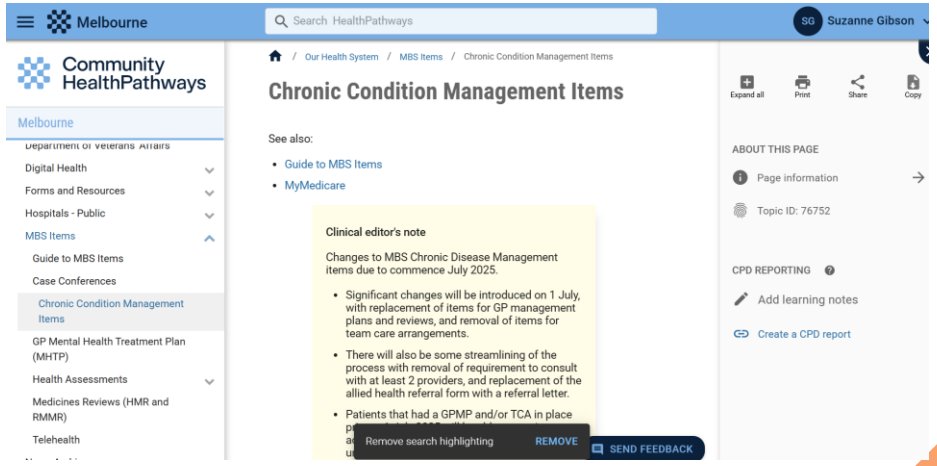
Q & A

EMPHN resources

- EMPHN CCM flowchart
- EMPHN Practice Nurse resource
- HealthPathways Melbourne

https://emphn.org.au/for-health-professionals/healthpathways-melbourne/





Close

Thank you for joining us today.

Please take a moment to complete the evaluation survey

An email with presentation recording and resources will be sent in the next week.

https://www.surveymonkey.com/r/BBBT57W

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For further information and support:

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