Transforming Clinical Care | The Webinar Series

Webinar #5 of 7 (Recorded)

Primary Care Innovation

Optimising GPCCMPs

Funded by Healthy North Coast through the North Coast PHN program

Acknowledgement of Country

Primary Care Innovation acknowledges Traditional Owners of Country throughout Australia and recognizes the continuing connection to lands, waters and communities.

We pay our respect to Aboriginal and Torres Strait Islander cultures, and to Elders past and present.

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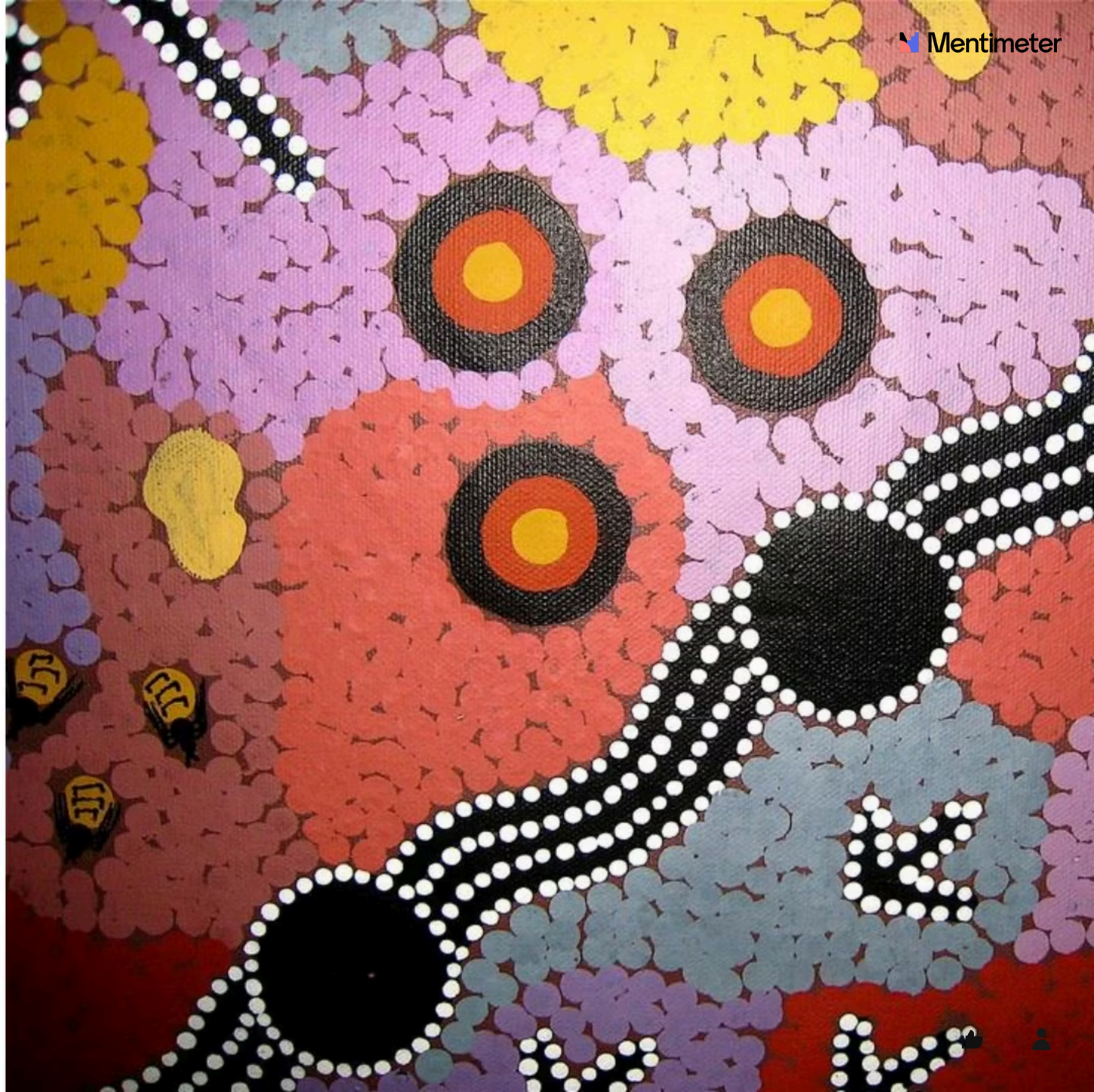

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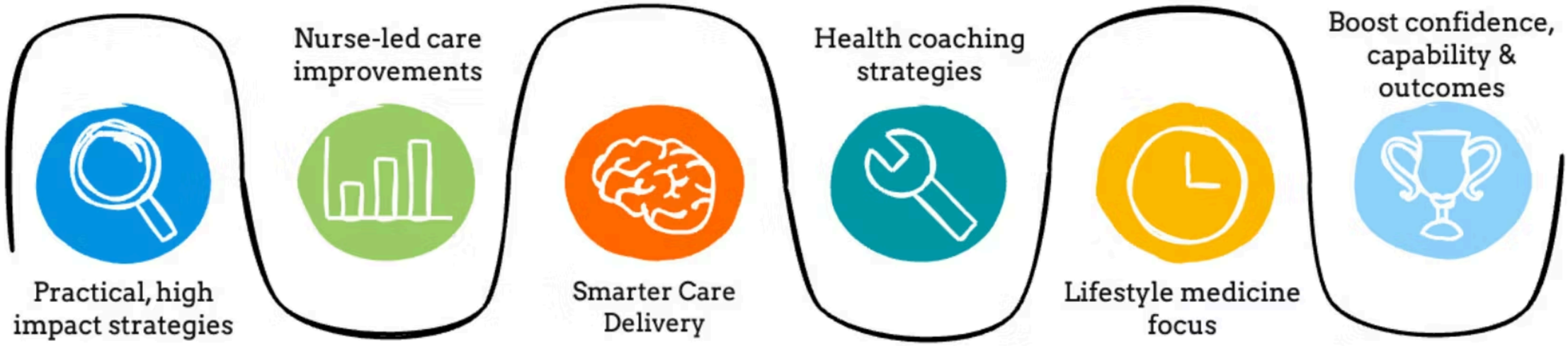

The Webinar Series

1. A Framework for nurse-led Clinics
2. Planning, Goal Setting with patients & Health Coaching
3. Patient Engagement via Coaching Voices
4. Optimising Health Assessments
5. Optimising GPCCMPs
6. Optimising QI-PIP and Indigenous Health Incentives
7. GPiACI & Palliative Care

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What We're Covering Today

Primary Care Innovation

01 GPCCMP Foundations & the Optimisation Opportunity

02 Engaging Your Team & Your Patients

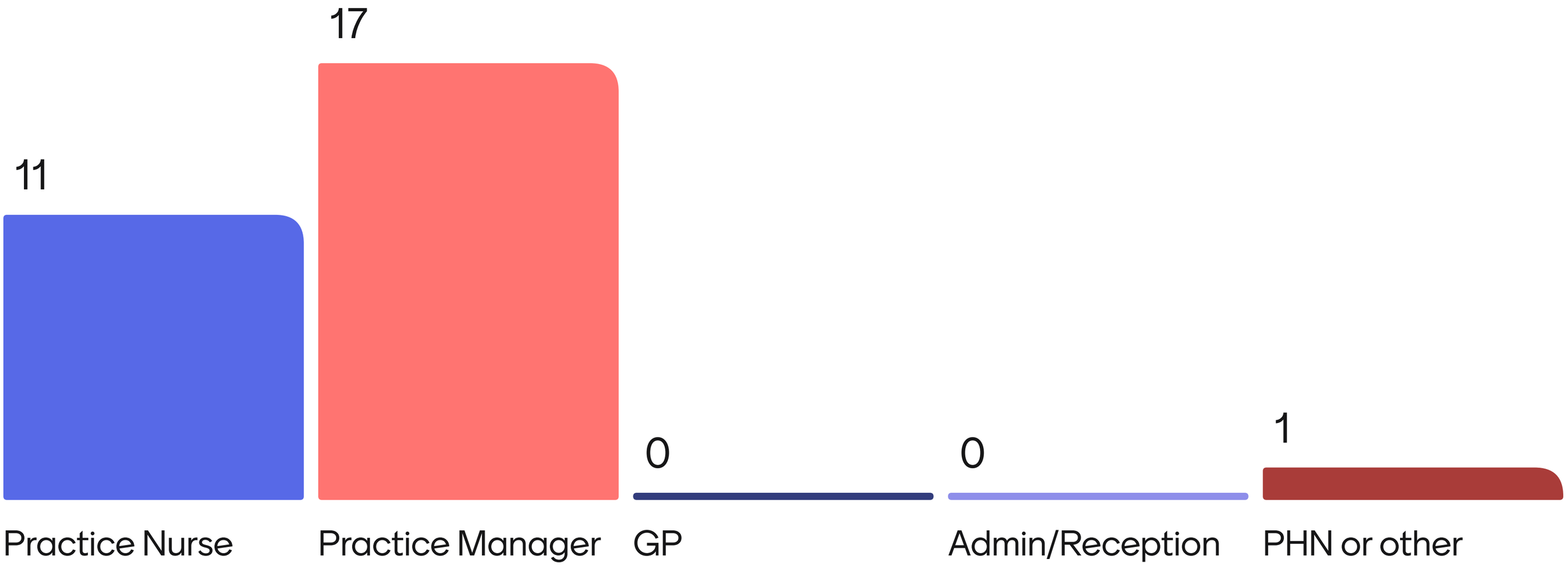
03 Workflows, PREMs & PROMs

04 Guest Speaker: Case Conferencing in Practice

05 AI Tools & Living Documents

06 Key Takeaways, Resources & Q&A

What's your primary role?



What is a GPCCMP?

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Item 965: Preparation

GP Management Plan
For patients with a chronic or terminal condition expected to last 6+ months
Involves:

- Identifying patient care needs
- Setting patient health goals
- Identifying actions to be taken
- Coordinating services with other providers

Item 967: Review

GP Management Plan Review
Structured review of the plan's progress and goals
Includes:

- Review of patient's health status
- Review of whether goals are being met
- Review of actions and services in place
- Updating the plan as required

The Optimisation Opportunity

Why 'set and forget' isn't working

Plans without reviews have limited impact

Research shows that care plan initiation alone is not associated with improved clinical outcomes for diabetes or cardiovascular disease. It is regular review that drives results.

BMC Primary Care, 2022

Review reduces hospitalisations

In adults with diabetes, review (not initiation) of a care plan was associated with reduced all-cause hospitalisations. Proactive reviews were more protective than plan creation alone.

AIHW Chronic Disease Management, 2019

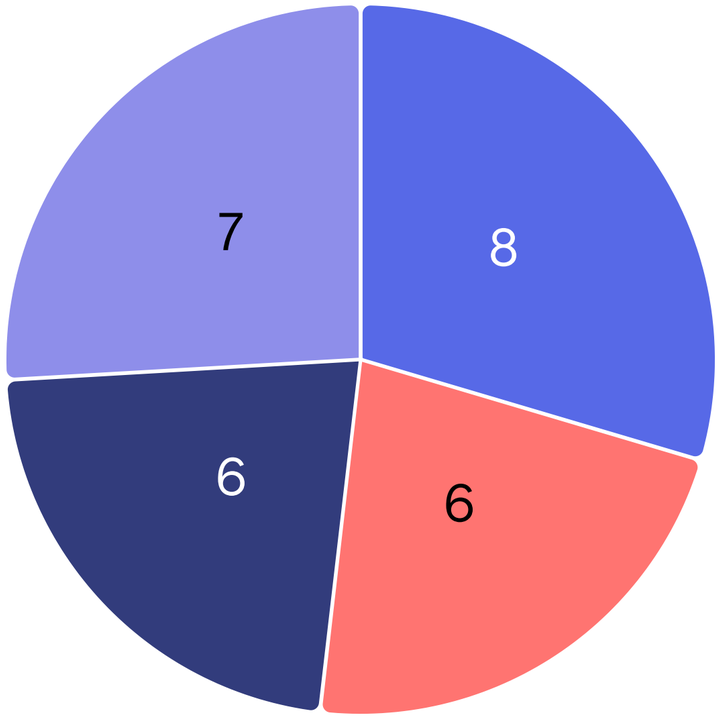
Item 967 is consistently underutilised

Despite equalised fees under the new GPCCMP framework, review items are claimed at much lower rates than plan preparation. The gap between initiation and review is a key opportunity.

MBS data & BMC Primary Care, 2022

The evidence is clear: regular structured reviews are where the clinical and practice improvement opportunity lies, not plan creation alone.

How often are your GPCCMPs reviewed on schedule?



8	Almost always
6	About half the time
6	Rarely
7	We're working on it!

Engaging Your Practice Team

Roles, barriers and practical strategies for success

GP	Plan creation, clinical oversight, reviews, billing
Practice Nurse	Nurse-led reviews, patient check-ins, recall management
Care Coordinator	Referrals, tracking allied health, patient follow-up
Admin	Scheduling, recall systems, patient reminders

Quick Wins

- Weekly team huddle to review care plan recall list
- Nurse-led review model (see Dec 2025 webinar)
- Defined templates in Best Practice / MedicalDirector
- Automated recall reminders via SMS or app
- Assign a dedicated 'care plan champion' in the practice

Engaging Your Patients for Buy-In

Practical scripts, language and coaching approaches

Why Patients Don't Engage

- "I feel fine, why do I need to come in?"
- Confusion about what a care plan is
- Low health literacy or language barriers
- Cost, transport or time concerns

Coaching Voices (Feb 2026)

Compassionate Listener · Motivational Mirror · Gentle Challenger
Reflective Practitioner · Curious Collaborator · Clarity Coach

Apply these voices when introducing or reviewing a GPCCMP

Practical Scripts & Approaches

"This plan is your roadmap. We build it together."

Jan 2026 session: SMART goal planning & reviewing, nurse check-ins, SNAP discussions, health coaching
Feb 2026 session: Patient engagement via Coaching Voices: practical framing for care plan conversations
Both recordings available at primarycareinnovation.com.au

What's your biggest challenge with patient engagement in care plans?

13 Explaining the value to patients

7 Getting patients to attend reviews

1 Language or literacy barriers

1 Not enough time in the consult

5 Something else (use Q&A box to describe)

Making Goals Meaningful

Which goal type works best for your patient?

SMART Goals

Specific, Measurable, Achievable, Relevant, Time-bound

Good for structured, motivated patients. Clear accountability. Easy to review.

"Walk 30 minutes, 3x per week, for the next 3 months"

Open Goals

Patient-directed, values-based, not time-bound

Better for complex patients or those with low confidence. Aligns with what matters most to them.

"I want to feel well enough to play with my grandchildren"

'Do Your Best' Goals

Effort-focused rather than outcome-focused

Research shows these often outperform SMART goals: they reduce anxiety and increase intrinsic motivation.

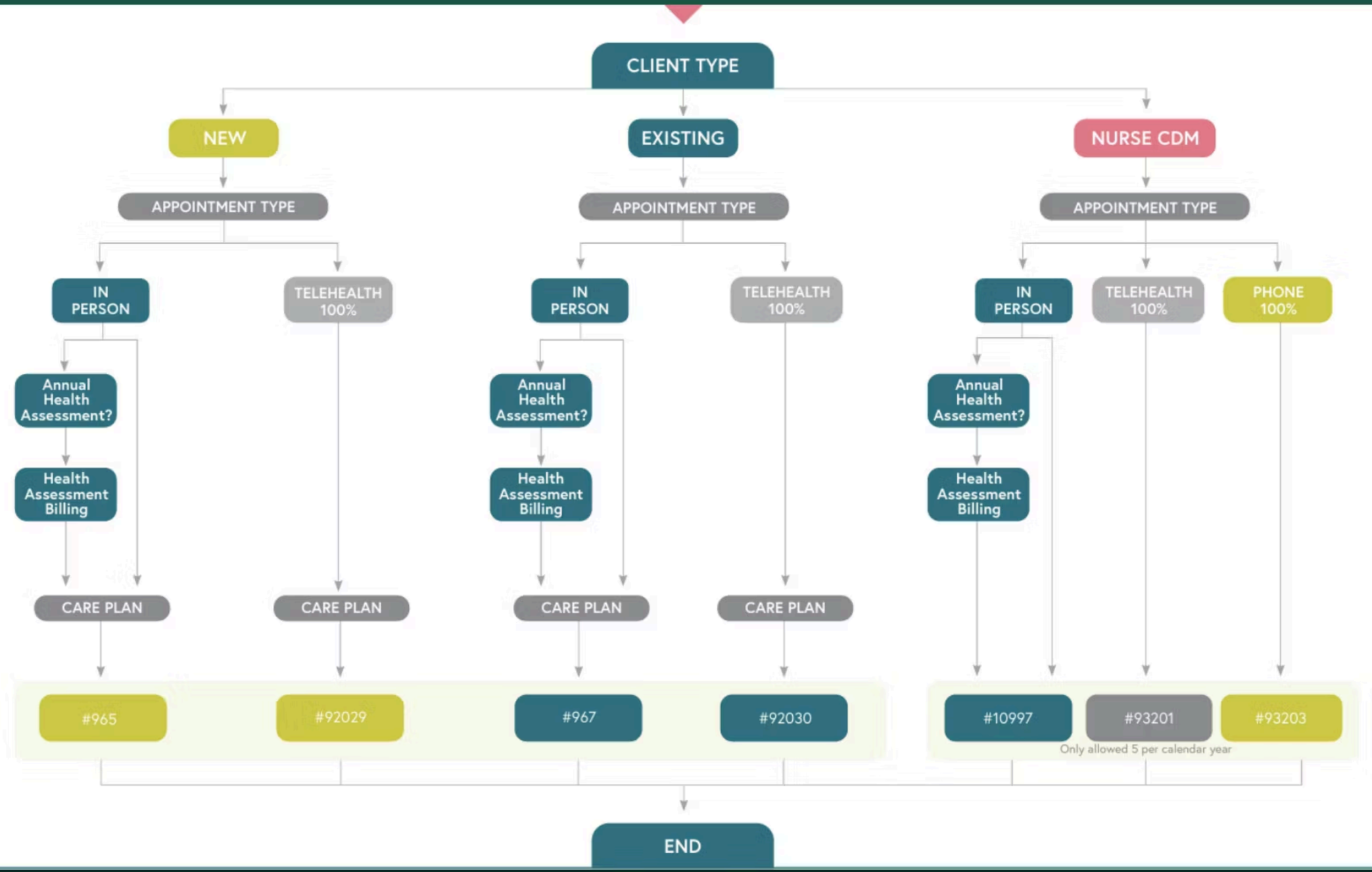
"Just do your best to be more active each week"

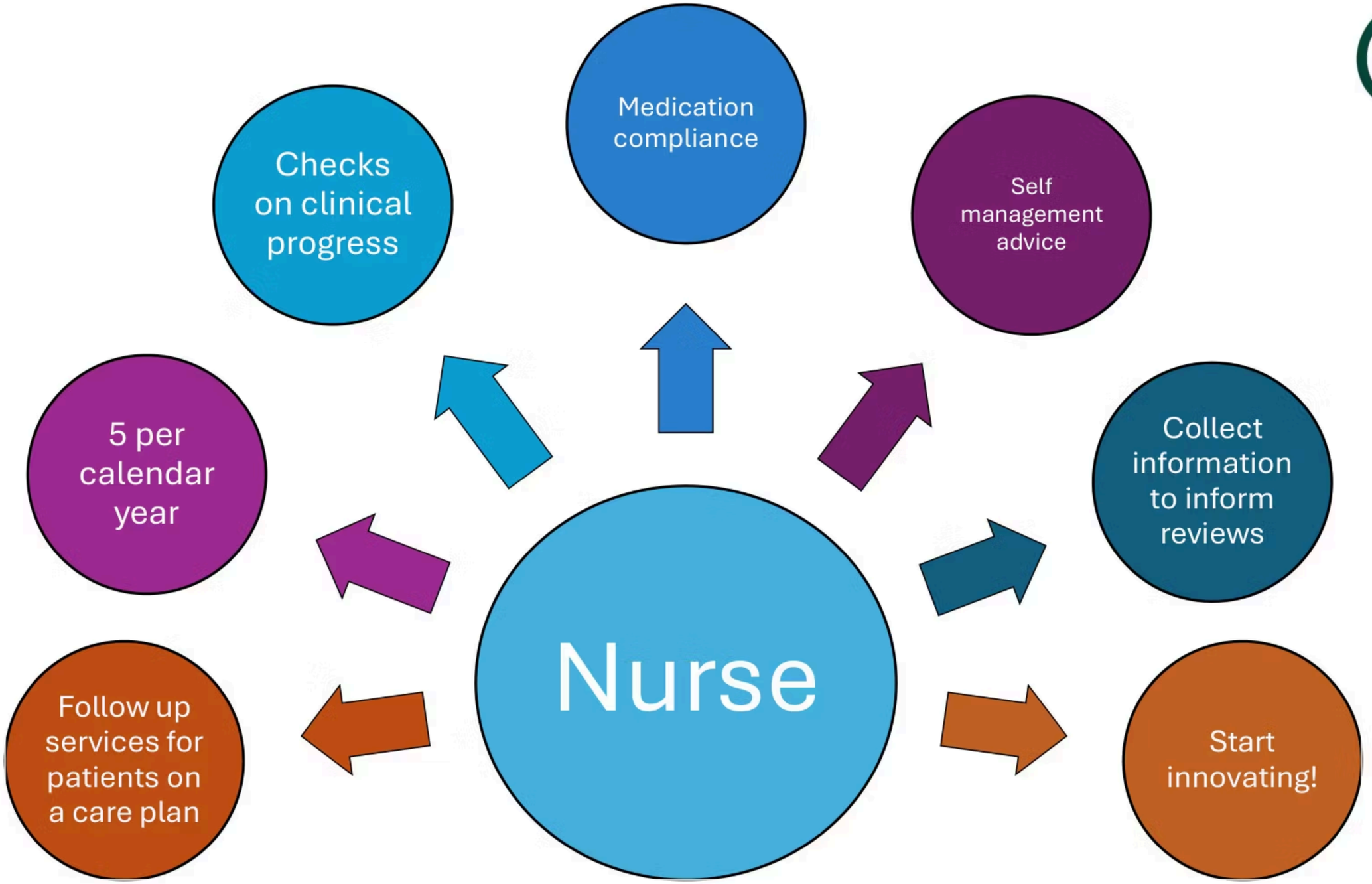
The Care Plan Lifecycle

A best-practice GPCCMP workflow

Recall & Reminder Systems: Use automated SMS/app reminders at 4 weeks, 2 months, and 1 week before review. Admin books; nurse conducts. GP reviews and updates plan.

HEALTH ASSESSMENTS & CARE PLANNING WORKFLOW




Medication compliance
Checks on clinical progress
Self management advice
5 per calendar year
Collect information to inform reviews
Nurse
Follow up services for patients on a care plan
Start innovating!

PREMs & PROMs: What is the difference?

Two distinct lenses on patient experience and health

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PREMs tell you how care was experienced. PROMs tell you whether health actually changed. Both are needed for a complete picture.

PREMs | Patient Reported Experience Measures

What they measure:

How the patient **experienced the process** of care: communication, respect, shared decision-making, coordination and access.

Example question:

"Did you feel involved in decisions about your care?"

Example tools:

- CFEP PAIS (Practice Accred & Impr Survey) RACGP endorsed 5000+ practices
- Insync RACGP endorsed
- CFEP PPiC (Pt partnership in care)

PROMs | Patient Reported Outcome Measures

What they measure:

The patient's ***health status***, symptoms, function and quality of life, reported directly by the patient rather than from clinical notes.

Example question:

"How much has your pain affected your daily activities this week?"

Validated tools:

- K10 (psychological distress)
- DASS-21 (depression, anxiety, stress)
- AQoL Assess of quality of life (free!)
- ACSQHC for full listings (links available in resources)

Developing Your Own Practice PREM

A practical approach

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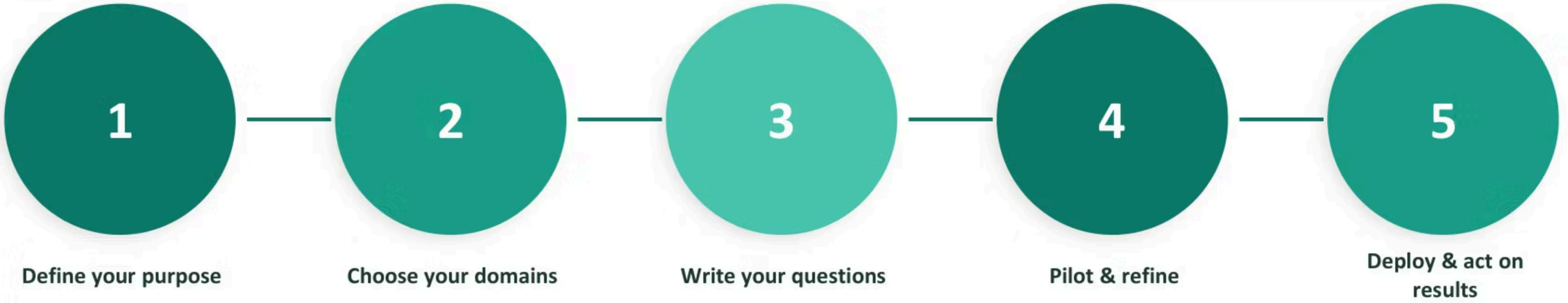
Example questions: 'Did your GP listen to you?' · 'Were you involved in your care plan decisions?' · 'What could we do better?'



1. Define purpose

Is this for QI, accreditation, patient feedback or care plan review? Keep it focused. Ensure questions meet Standards requirements

2 & 3. Domains & questions

Cover: access, communication, shared decision-making, care coordination, overall experience. Use plain language. Aim for 5-8 questions. Mix Likert scale (1-5) with 1-2 open text fields.

4. Pilot & refine

Trial with 10-20 patients first. Check: Do they understand the questions? Is it quick to complete (under 3 min)? Adjust wording before rolling out.

5. Deploy & Act on results

Consider QR code for ease of use. Share results with the team. Identify one thing to change. Repeat the survey after the change to see if it worked or use for ongoing feedback.

How are you currently using PREMs? (Experience measures)

No

No

No

No

No.

No

no

No

How are you currently using PREMs? (Experience measures)

No	No	N0	No
Yes	No	Yes	Yes we use CFEP Paid - accreditation surveys?

How are you currently using PREMs? (Experience measures)

No

No

No

No

No

Mostly unscheduled feedback Nothing formal

Some elements but not that specific model

No usage

How are you currently using PREMs? (Experience measures)

Yes. We use CFEP for accreditation, then our own clinic one at reception

Case Conferencing in Practice

Chiron Weber | Healthy North Coast PHN

Medicare Case Conferencing Items 735 / 758

Virtual MDT models · Remuneration structures · Real-world implementation

A Practice's Approach to Case Conferencing

Link to 'Case Conferencing eLearning Module' 2.5 hours FREE!

The Virtual MDT Model

- Allied health professionals brought into a virtual environment
- GPs access the team on behalf of patients, when needed, not by referral alone
- Regular virtual case conference meetings scheduled
- Streamlined communication across disciplines

Medicare Items 735 / 758

- Item 735: GP participates in a case conference (>15 min)
- Item 758: GP organises and coordinates case conference
- Eligible: patients with a chronic condition, at home or in the community
- Allied health, specialists and other care providers can claim separately

Remuneration Structures

- GP: items 735/758 claimable on top of standard consultation
- Allied health: separate Medicare items available for participation
- Model makes case conferencing financially sustainable for all parties
- Practice revenue uplift from better CDM item utilisation

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GPCCMPs as Living Documents

Moving from static paperwork to dynamic care tools

Where AI Can Help

- Drafting care plan text from consult notes
- Identifying patients overdue for review
- Automated recall and reminder workflows
- Clinical decision support and prompting
- Patient communication and education content

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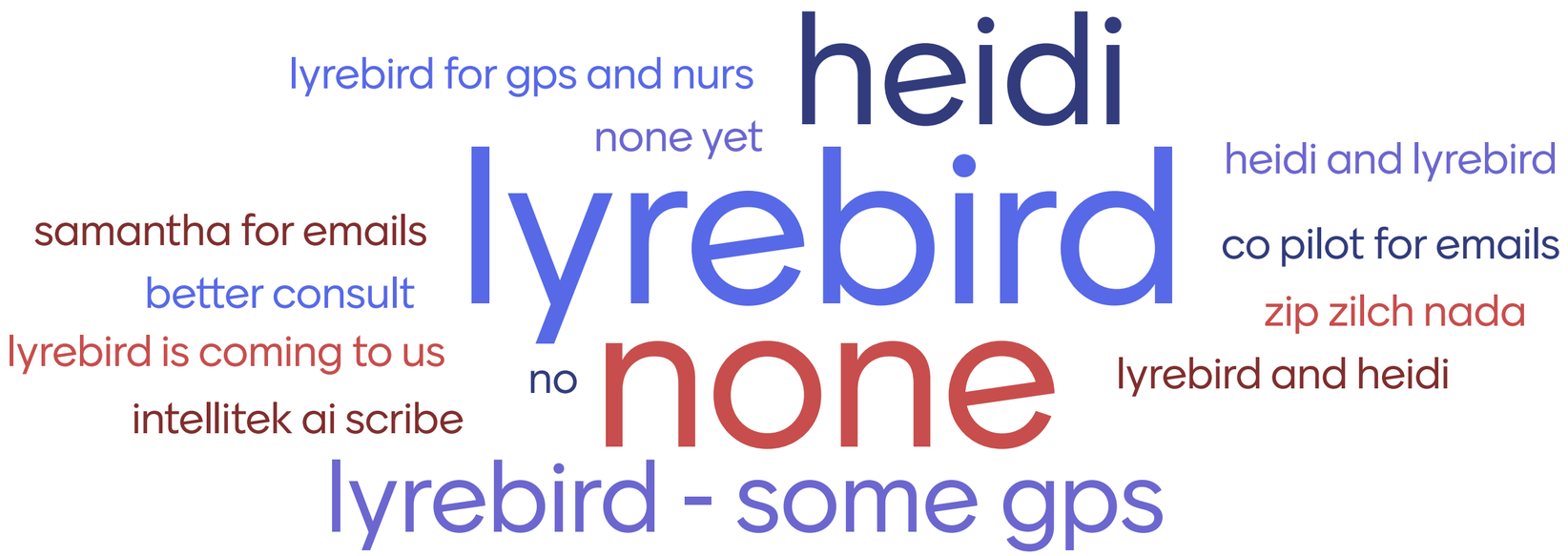
Tools in Practice

Cubiko Insights
Lyrebird (BP Partner)
Heidi Health & Evidence
Coviu AI Scribe
BetterConsult
MyGPMPTool

⚠ Guardrails

- Clinician always reviews AI output
- Patient consent for AI use
- Check accuracy (AI can hallucinate)
- Follow your software's privacy guidelines

What AI tools are you currently using in your practice?



Key Takeaways

1. Items 965 & 967 are underutilised: structured reviews are where the opportunity lies
2. A clear team structure with defined roles transforms GPCCMP quality and completion rates
3. Match your goal approach to your patient: SMART, Open, or 'Do Your Best' goals all have a place
4. PREMs & PROMs close the loop: patient-reported data should drive care plan updates
5. AI tools and living documents keep care plans relevant, but the clinician always leads

Mentimeter

Thank You!

Coming Up: 13 May 2026

Optimising QI-PIP and Indigenous Health Assessments

QI-PIP fundamentals · Indigenous Health Incentives · Beyond data submission

Resources & Evaluation

All recordings & resources:
primarycareinnovation.com.au

Please complete the brief evaluation.
Your feedback shapes the series!

Q&A: Open Floor | Use the Q & A panel

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