Activity 2 – Patient identification and management

Activity 2A Patient Management: CCM existing and returning patients	
Registering all returning CDM patients for MyMedicare with your practice prior to, or at their next CDM appointment.	Prompt your patients to register in advance of their appointments. • Send an SMS to all patients with a scheduled Chronic Disease Management Plan encouraging them to register with your General Practice before their appointment using Medicare Online or print and complete a MyMedicare Registration form to bring to their appointment, or • Invite patients to attend their appointment early to complete a MyMedicare Registration Form in the practice waiting room. Encourage your patients to register at their next appointment • Check each patient's MyMedicare Registration status with your practice when they present for their appointment or the day before their appointment • Provide a MyMedicare Registration QR code or MyMedicare Registration form when patients present to the practice, and encourage them to complete their registration, or discuss registration as part of their Chronic Disease Management appointment • Have your practice nurse or Aboriginal Health Practitioner assist the patient with completing the registration for as part of their Chronic Disease appointment. This provides an opportunity for a conversation about expectations of an ongoing care relationship so that the practice can support the patient's health journey in the long term.
Activity 2B: Practice workflows	
Develop a process for booking future review appointments for any patient you put onto a Chronic Disease Management Plan.	• Consider and develop a method for how your practice will approach scheduling review appointments. You may decide to adopt a standard 3-month review or 6-month review approach or require the clinical team to advise on the review timelines informed by their clinical judgement on a case-by-case basis. • Develop workflows for reception – to ensure that as the patient is handed over to reception before they leave your practice reception has an action to schedule their next appointment, understands the timeframe for review to inform scheduling, and communicates the appointment time and date clearly to the patient (SMS, or reminder card, or other) • Develop a process for appointment reminders in the leadup to review appointments – frequency (e.g. 1 week and 24 hours) and modality (phone call or SMS) to ensure your attendance rates for review

	appointments remain high. Include message for patients to check Medicare Online to ensure they are registered for MyMedicare with your practice, document any questions to bring to the appointment.
Activity 2C: Develop clear communication	
Develop a clear communication for why review appointments are important to attend for your practice team and patients (including if there are out of pocket costs for the patient).	• Review your process and strengthen how you document priorities and actions due for the next review appointment in the patients' medical record in your practice software as part of all Chronic Disease Management Plans and Reviews. For example, document any: ▪ Outcomes, goals or targets the patient has for their review appointment ▪ Education or points of discussion planned for the review appointment ▪ Tests or pathology due that need to be scheduled ▪ Referrals that need to be completed • Communicate the importance of the review appointment with your patient and their carers (if appropriate) including: ▪ Emphasize the importance of the review plan focusing on actions for the patient and why the review is needed with your patient at the conclusion of the appointment ▪ Provide patient with a printed copy of the care plan and review appointment plan ▪ Outline expectations and processes to re-schedule review appointment ahead of time • Develop messaging for patients about the benefits of proactive care, care when you are not acutely unwell, or keeping you well. Develop communications to support this in your practice, for example: ▪ Waiting room posters targeting CDM patients • Talking points for the practice team to reinforce the importance of reviews and attending for care when patients are not acutely unwell
Activity 2D: Embedding sustainable processes to manage missed or cancelled patient review appointments.	
QI: Review and strengthen your process to manage missed or cancelled patient review appointments. Document the process for how to manage cancellations or missed review appointments.	Consider: • How is the cancellation or non-attendance documented? For example, will your practice flag the patient, or retain a list of patients that need to be re-scheduled? • Who needs to be notified? (e.g. Nurse or Aboriginal Health Practitioner with responsibility for Chronic Disease coordination, and the patients usual GP)

	• What are the standing arrangements for re-scheduling CDM review appointments? For example, does your practice aim to re-schedule within 2 weeks of the cancellation or follow up non-attendance with a phone call to reschedule as a standard operating procedure? • Are there any data searches that need to be completed at regular intervals to identify any patients that may have missed their appointment but have not been re-scheduled? For example, you could run a report from your clinical practice software for patients that have not had a review in more than 6 months and provide this list to a Nurse or Aboriginal Health Practitioner with responsibility for Chronic Disease coordination for review and action to check for any patients that have missed their scheduled review.