

Creating a Medication Management Plan

Best Practice

Claim Medicare Item 900 after developing a written **Medication Management Plan (MMP)** in accordance with MBS requirements. This should follow a discussion with the patient upon receipt of HMR/DMMR report.

1. Open the **Patient Clinical File**.
2. Open **Letter Writer** by clicking on the Letter Writer Icon.

Name: Anastasia Abbott D.O.B.: 25/02/2004 Age

Address: 12 John St Albany Creek 4035 Phone: (h) 07 50505050

Medicare No: 4133180467 12/08 Record No.: 104 Pension No.:

Occupation: Tobacco: Parity: Pre

| Item | Reaction | Severity | Type | Due |
|---------------------|-------------|----------|----------------------|----------|
| Penicillin | Anaphylaxis | Severe | Outstanding requests | 11/01/21 |
| Aluminium Hydroxide | Diarhoea | Moderate | Preventive health | 30/04/21 |
| Trafi | Nausea | Moderate | | |

3. Select **Templates** from the top drop-down menu and select **Use Template**.

Word Processor - Untitled

View Insert Format Table **Templates** Utilities Help

- New template
- Edit template
- Import template
- Export template
- Use template**
- Edit letterhead
- Customise system templates

4. Select **Supplied** template tab.
5. Double click supplied **DMMR – Form2**.

Word Processor templates

All
 Custom
 Supplied
 Include all states

| Template name | All users | Type |
|------------------------------------|-----------|----------|
| Continuing care referral | Yes | Supplied |
| CRS Sleep Services referral | Yes | Supplied |
| CTG - Patient consent | Yes | Supplied |
| CTG - Patient registration | Yes | Supplied |
| CTG - Patient withdraw consent | Yes | Supplied |
| CVS Referral | Yes | Supplied |
| CVS Vascular referral | Yes | Supplied |
| D904 Veteran's Affairs | Yes | Supplied |
| Division referral | Yes | Supplied |
| DMMR - Form1 | Yes | Supplied |
| DMMR - Form2 | Yes | Supplied |
| EPC - Referral for Type 2 Diabetes | Yes | Supplied |
| EPC Dental care | Yes | Supplied |
| EPC Follow-up Referral, ATSI | Yes | Supplied |
| EPC Referral | Yes | Supplied |
| eReferral | Yes | Supplied |
| GP Mental Health Care Plan | Yes | Supplied |
| GPMP/TCA | Yes | Supplied |
| Healthy kids | Yes | Supplied |
| Healthy kids 709 | Yes | Supplied |
| HeartSTART Referral | Yes | Supplied |
| K10 Assessment | Yes | Supplied |
| Medical certificate | Yes | Supplied |

6. Complete relevant fields.
7. Include Credentialed (Accredited) Pharmacist name if different to Community Pharmacist name.
8. Select **insert**.

DMMR - Form2

| | |
|------------------------------|---|
| Patient / carer contact | <input type="text"/> |
| Follow-up consultation | <input type="text" value="21/05/2024"/> ▾ |
| Community Pharmacist Name | <input type="text"/> |
| Community Pharmacist Address | <input type="text"/> |
| Community Pharmacist Phone | <input type="text"/> |
| Community Pharmacist Fax | <input type="text"/> |
| Community Pharmacist Email | <input type="text"/> |
| Accredited Pharmacist Name | <input type="text"/> |

9. Complete the table ensuring all fields are filled and patient agrees to proposed plan of action.

Please note: To manually check a box, **backspace the box and press 'X' on the keyboard.** This will add a check box symbol.

| DOMICILIARY MEDICATION MANAGEMENT - HOME MEDICINE'S REVIEW: MEDICATION MANAGEMENT PLAN | | | | | |
|--|--|---|--|---|--|
| GENERAL PRACTITIONER DETAILS: Name: Dr Frederick Findacure Address: 1 Best Avenue PracticeLand 4001 Provider Number: ***** Prescriber No: ***** Phone: 0744444444 Fax: 0744444445 Email: findacure@bpsoftware.com.au Date of Pharmacist Review | | PATIENT DETAILS: Name: Miss Anastasia Rose Abbott Address: 12 John St Albany Creek 4035 Medicare No: 4133190467 DVA No: Patient / carer contact: Test Date of follow-up consultation: | | COMMUNITY PHARMACY: Name: Test Address: Phone: Fax: Email: ACCREDITED PHARMACIST (if different) Name: Test | |

| CURRENT CONDITION/PROBLEM | CURRENT MANAGEMENT* | PROPOSED PLAN OF ACTION | PERSON RESPONSIBLE FOR ACTION** | EXPECTED OUTCOMES | PATIENT AGREES |
|---------------------------|---------------------|--|---------------------------------|-------------------|----------------|
| | | <input type="checkbox"/> No action required <input type="checkbox"/> Action (comment): | | | |
| | | <input type="checkbox"/> No action required <input type="checkbox"/> Action (comment): | | | |
| | | <input type="checkbox"/> No action required <input type="checkbox"/> Action (comment): | | | |
| | | <input type="checkbox"/> No action required <input type="checkbox"/> Action (comment): | | | |
| | | <input type="checkbox"/> No action required <input type="checkbox"/> Action (comment): | | | |
| | | <input type="checkbox"/> No action required <input type="checkbox"/> Action (comment): | | | |

*pharmacological and/or non-pharmacological

** nominate other health care professional if applicable

General Practitioner _____

Patient _____

Date _____

Attach additional information if necessary.

Additional forms are available through Leigh Mardon: 1800 067 307. Please quote form #2970.

Copy to be offered to patient & Pharmacist

10. Attach additional information as necessary.
11. Print, date, both parties sign completed documentation.
12. Offer a copy of the medication management plan to the patient.
13. Send a copy of the medication management plan to the Credentialed Pharmacist and/or Community Pharmacy and other relevant health professionals by chosen secure messaging method.
14. Claim MBS Item 900.