Version 3.89

cdmNet

User Manual

How to register, install and use cdmNet

precedence healthcare

Australian Government

State Government Victoria AUSTRALIA

cdmNet Help Desk

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1 An Introduction

The aim of this document is to help GPs and practice nurses effectively use Precedence Health Care's Chronic Disease Management Network (cdmNet) to maximise the benefits to patients and to the practice.

cdmNet provides the following benefits to healthcare providers and patients:

- Evidence shows that properly personalised and well-managed care plans can significantly improve health outcomes for patients with chronic disease.
- Individual accounts that provide faster and easier creation of best practice GP Management Plans (GPMPs), Team Care Arrangements (TCAs), and GPMP and TCA Reviews.
- Automation and streamlining of documentation and MBS CDM compliance processes.
- Higher quality care plans using best-practice guidelines and personalised to patient needs.
- Improved health outcomes for patients resulting from use of best practice personalised care plans and tracking of patient actions to ensure compliance with management goals.
- Improved sharing of information and continuity of care across the care team and with the patient through the cdmNet web portal.
- Improved communication and coordination between the GP and other care team members facilitated through the use of email, SMS, and the cdmNet web portal.
- Increased practice revenues through increased throughput of MBS to Chronic Disease Management (CDM) items and Practice Incentive Payments (PIP).
- Further incentives for Home Medication Reviews, which are recommended for many patients with chronic disease and complex conditions.
- 'Duty of care' and compliance support for GPs and other providers through automated reminders and alerts to patients and the care team.
- Greater visibility of the care planning process through the provision of reports and summaries detailing current care plan status and health outcomes for all patients.
- All patients on a care plan are regularly reviewed and the results of reviews are shared with the care team.
- cdmNet can be used either directly by a GP or in collaboration with a practice nurse.
- cdmNet also allows the patient to track their own care plan and provides reminder and alert services to help the patient adhere to this plan.

cdmNet is available for people with the following chronic diseases, either singularly or as comorbidities:

- Asthma
- Chronic Heart Failure
- Chronic Kidney Disease
- Chronic Low Back Pain
- Chronic Obstructive Pulmonary Disease
- Coronary Heart Disease
- Depression (as a comorbidity)
- Diabetes Mellitus Type I
- Diabetes Mellitus Type II
- Hepatitis B
- Hepatitis C
- Mental Health
- Osteoarthritis
- Post-Surgery Breast Cancer
- Preventive Health
- Refugee/Immigrant Health
- Stroke

It is also possible to create customised care plans for any chronic disease or complex condition.

(An additional option to "Generate a standard cdmNet care plan for the selected conditions" may appear if a patient is participating in certain programs.)

1.1 Your Role

As a registered provider, you could have one or more of the following three roles, depending on your association with a particular patient:

1. A Primary Care Provider (or PCP) – this is usually GPs and Nurse Practitioners;
2. A Care Plan Creator (or CPC) – this can be any speciality; and
3. Care Team Member – this can be any speciality.

If you are a Primary Care Provider or a Care Plan Creator, you have more ability to modify patient information and care plans.

If you are a Care Team Member, you may only be able to view information about patients and edit limited information about a patient's care plan.

2 How to Get Started

To get started with cdmNet, there are just a few simple steps to follow:

1. Register with cdmNet (see Chapter 2.1 Register with cdmNet);

If you are a GP, Practice Nurse, Practice Manager or otherwise working in a Primary Care Practice, there are four additional steps:

2. Install cdmNet Desktop onto your computer desktop (if not already installed) (see cdmNet Desktop Guide, available at **cdm.net.au/help/guides**);
3. Set up your cdmNet username and password on your desktop to allow automatic login (see cdmNet Desktop Guide, available at **cdm.net.au/help/guides**);
4. Set up your provider preferences in cdmNet (see Chapter 7 Preferences); and
5. Accept the Service Agreements for GPs to agree to pay any cdmNet fees (see **cdm.net.au/serviceagreementterms**).

2.1 Register with cdmNet

To register with cdmNet, go to **cdm.net.au/register.**

You first need to provide your general details as a provider.

Fill in your details in the boxes provided. A red dot indicates that some fields are mandatory.

A valid method of contact must be provided so that cdmNet can send you notifications when necessary.

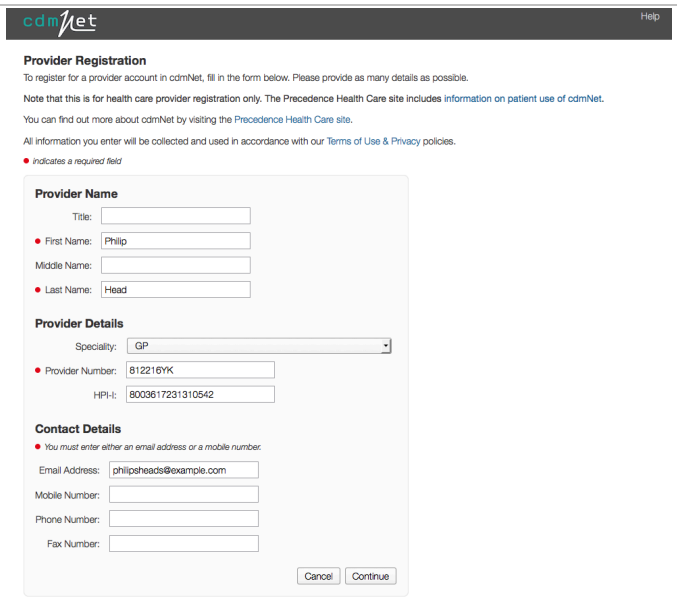


Figure 1. Registering Provider Details

After clicking Continue, you are prompted to add Practice or Organisation Details.

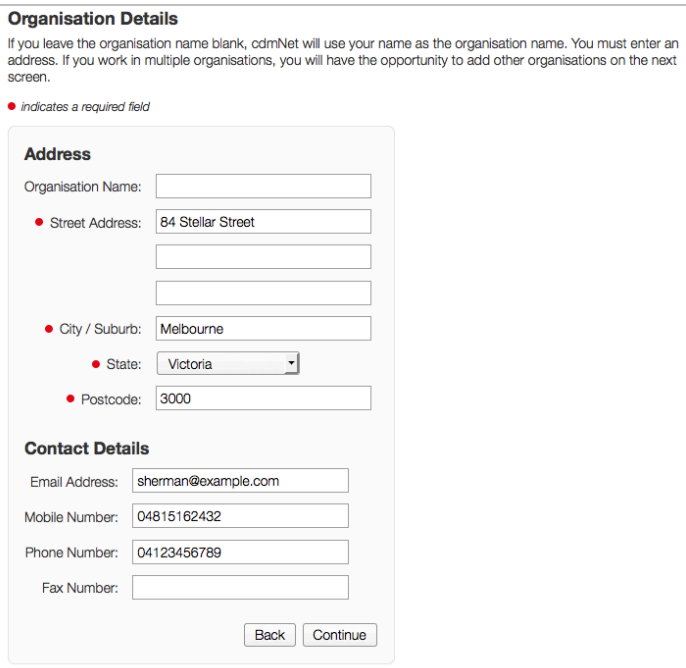


Figure 2. Register Organisation or Practice

Note that when you register, all registered providers within the same postcode of your organisation are added to your organisation's preferred provider list (see Chapter 7.6 Preferred Providers).

Depending on your speciality, you will have an opportunity to add more organisations on a later screen.

The following screen is displayed if cdmNet finds a matching organisation. However, for security and privacy reasons, cdmNet only adds you as a pending member of the organisation; you will need to ask someone within the organisation to accept your request to join the organisation (see Chapter 7.5.1 Adding Members to an Organisation).

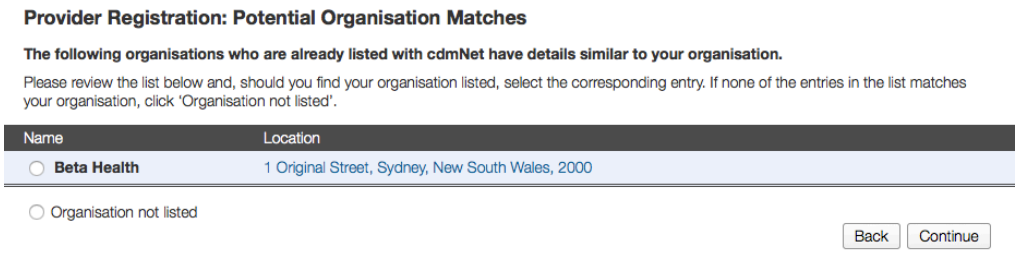


Figure 3. Organisation Match

The next screen confirms the details you have entered so far. Depending on your speciality you can click Add Another Organisation to enter details of any additional organisations you belong to. Once you are happy with the confirmed details and click Continue, cdmNet prompts you to set up a username and password. By default, cdmNet generates a username for you based on your details. You can, of course, change your username if desired. Remember your username and password for future reference.

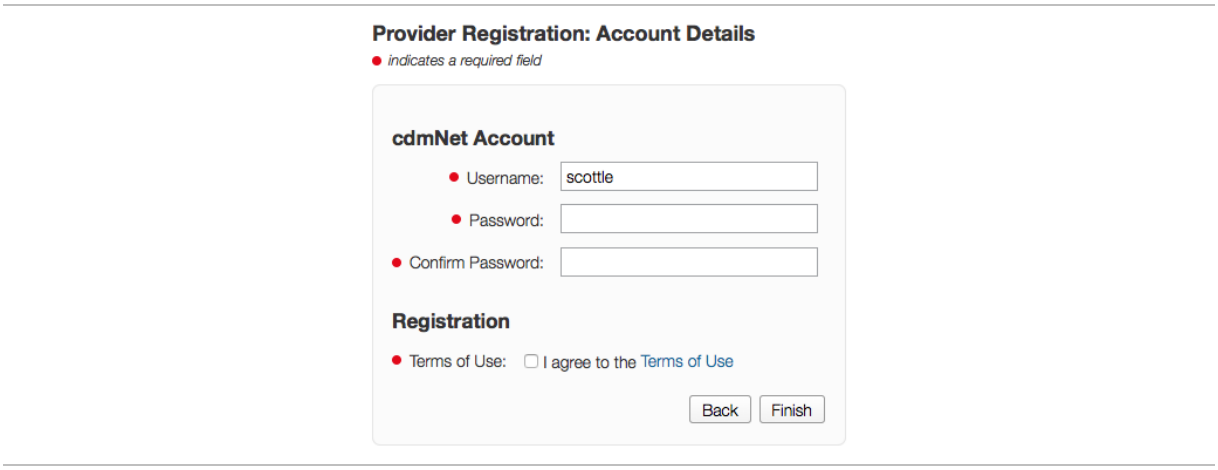


Figure 4. Username and Password Set Up

You must agree to the Terms of Use before continuing. You can view these terms in a new window by clicking Terms of Use.

After you click Continue, cdmNet sends you a welcome message.

3 Logging In

Once you have logged in, at the top right corner of the page, there are seven links. They are:

- Patients;
- Reports; (Only available if you are a PCP or CPC)
- Surveys*;
- Resources;
- Preferences;
- Help; and
- Log Out.

Figure 5. Seven Links in the Top Right Corner

(When you log in for the first time, cdmNet directs you to the Preferences section. It is recommended that you set up your Preferences at this point; see Chapter 7 Preferences.)

Each section and its extending functions will be explained in the order listed.

* Surveys may appear here from time to time, depending on various factors such as your geographical location, speciality and participation in research programs.

4 Patients

When you log in, cdmNet displays your patient list.

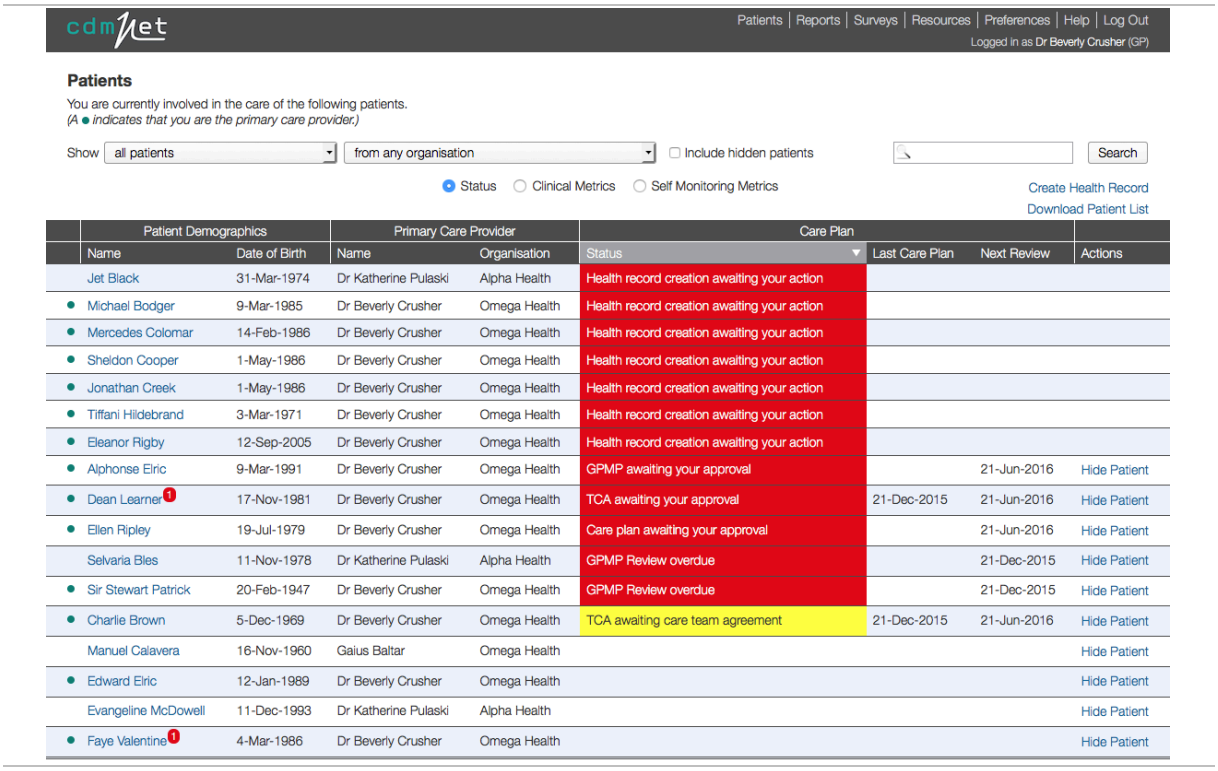


Figure 6. Patient List in Status View

To the left of the patient list, there are two filters. The first filter allows you to see:

- All patients;
- Patients with unsigned documents (Allied Health Forms and HMR Forms,);
- Patients awaiting action from you;
- Patients awaiting action from others;
- Patients with unseen notes;
- Patients not receiving notifications;
- Patients with after hours referrals; and
- Patients participating in programs.

(The 'patients with after hours referrals' choice will only display patients if you are participating in certain programs.)

(Choices for 'patients in programs' will only appear if you have any patients participating in programs.)

The second filter allows you to filter your patients:

- From any organisation;
- Where you are the primary care provider†;
- Where you have been assigned (where you as an individual are assigned to a task on a care plan);
- Where your speciality has been assigned (where you have been assigned to a task directly, or where your organisation has been assigned and your speciality has been selected.); and
- From specific organisations (organisations you belong to that are assigned to a task on a care plan, or where the primary care provider also belongs to the same organisation).

By default, cdmNet filters your patient list to show all patients, from any organisation (or if you are a Primary Care Provider, the list is filtered to all patients, where you are the primary care provider). You can filter your patient list by one or a combination of the two filters and your patient list remains filtered until you change it.

The 'Include hidden patients' box turns on or off the display of hidden patients. By default, this box is not ticked and remains that way until you change it (meaning that hidden patients are not included in the list).

There are three views of the patient list: Status, Clinical Metrics and Self Monitoring Metrics. You can sort the patient list by any column and it remains sorted by the view and column you select until you change it.

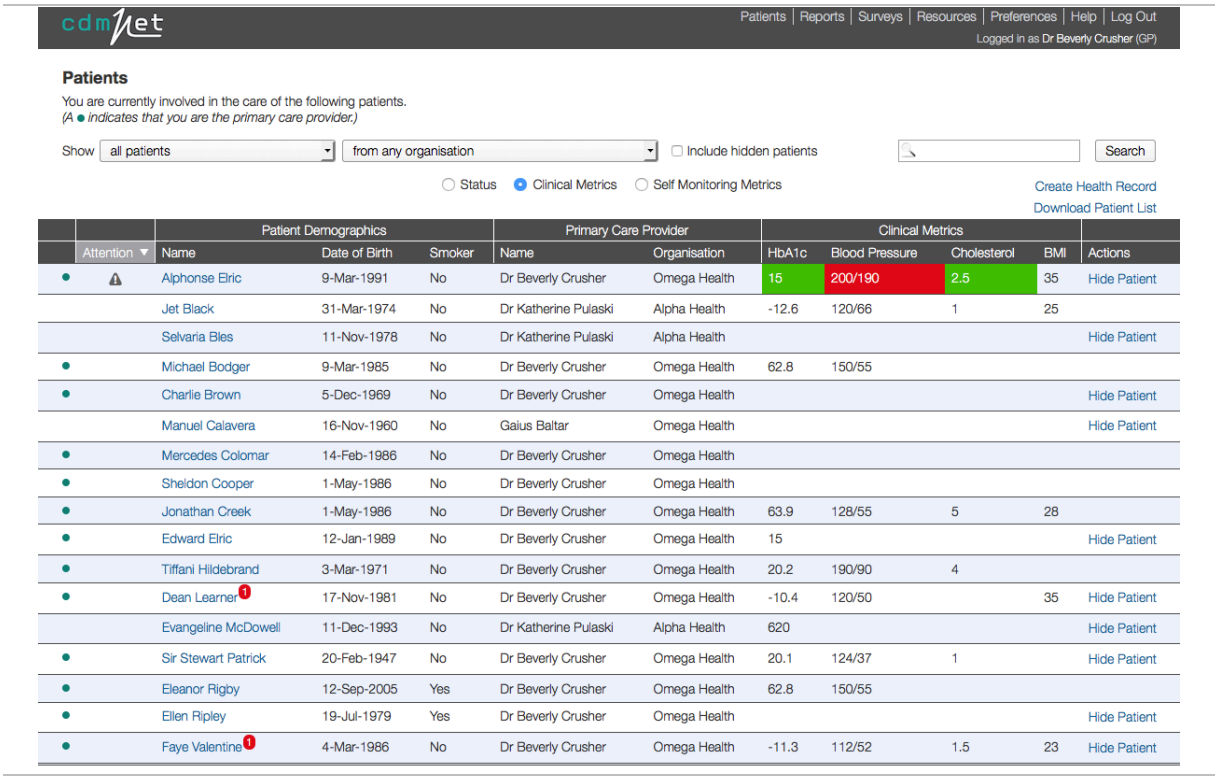
When you first view the patient list, the Status option is selected. The Status view of the patient list initially sorts patient records by the Status column under the Care Plan category.

The columns included in the Status view include:

- the name and organisation of the patient's Primary Care Provider;
- Status (the status of the patient's care plan);
- Last Care Plan (the date when the patient's care plan was approved);
- Next Review; and
- Programs (this column appears if you have any patients participating in a program).

The Clinical Metrics view of the patient list initially sorts the patient records by the Attention column.

† This filter only appears for GPs and providers who have the role of primary care provider.



		Patient Demographics			Primary Care Provider		Clinical Metrics				
	Attention	Name	Date of Birth	Smoker	Name	Organisation	HbA1c	Blood Pressure	Cholesterol	BMI	Actions
●	⚠	Alphonse Elric	9-Mar-1991	No	Dr Beverly Crusher	Omega Health	15	200/190	2.5	35	Hide Patient
		Jet Black	31-Mar-1974	No	Dr Katherine Pulaski	Alpha Health	-12.6	120/66	1	25	
		Selvaria Bles	11-Nov-1978	No	Dr Katherine Pulaski	Alpha Health					Hide Patient
●		Michael Bodger	9-Mar-1985	No	Dr Beverly Crusher	Omega Health	62.8	150/55			
●		Charlie Brown	5-Dec-1969	No	Dr Beverly Crusher	Omega Health					Hide Patient
		Manuel Calavera	16-Nov-1960	No	Gaius Baltar	Omega Health					Hide Patient
●		Mercedes Colomar	14-Feb-1986	No	Dr Beverly Crusher	Omega Health					
●		Sheldon Cooper	1-May-1986	No	Dr Beverly Crusher	Omega Health					
●		Jonathan Creek	1-May-1986	No	Dr Beverly Crusher	Omega Health	63.9	128/55	5	28	
●		Edward Elric	12-Jan-1989	No	Dr Beverly Crusher	Omega Health	15				Hide Patient
●		Tiffani Hildebrand	3-Mar-1971	No	Dr Beverly Crusher	Omega Health	20.2	190/90	4		
●		Dean Learner 1	17-Nov-1981	No	Dr Beverly Crusher	Omega Health	-10.4	120/50		35	Hide Patient
		Evangeline McDowell	11-Dec-1993	No	Dr Katherine Pulaski	Alpha Health	620				Hide Patient
●		Sir Stewart Patrick	20-Feb-1947	No	Dr Beverly Crusher	Omega Health	20.1	124/37	1		Hide Patient
●		Eleanor Rigby	12-Sep-2005	Yes	Dr Beverly Crusher	Omega Health	62.8	150/55			
●		Ellen Ripley	19-Jul-1979	Yes	Dr Beverly Crusher	Omega Health					Hide Patient
●		Faye Valentine 1	4-Mar-1986	No	Dr Beverly Crusher	Omega Health	-11.3	112/52	1.5	23	Hide Patient

Figure 7. Clinical Metrics View of Patient List

The columns in the Clinical Metrics view include:

- Attention (the 'attention' symbol appears if any new complications have developed within the last 6 months or if any of the clinical metrics have worsened since the patient's care plan was created);
- Smoker (whether the patient is known to be a smoker);
- the name and organisation of the patient's Primary Care Provider;
- HbA1c (in %);
- Blood Pressure (in mm/Hg);
- Cholesterol (in mmol/L);
- BMI (in kg/m^2); and
- Programs (this column appears if you have any patients participating in a program).

If you have an extensive list of patients, you can change the number of patients shown per page (up to 300).

The Self Monitoring Metrics view initially sorts the patient records by name.

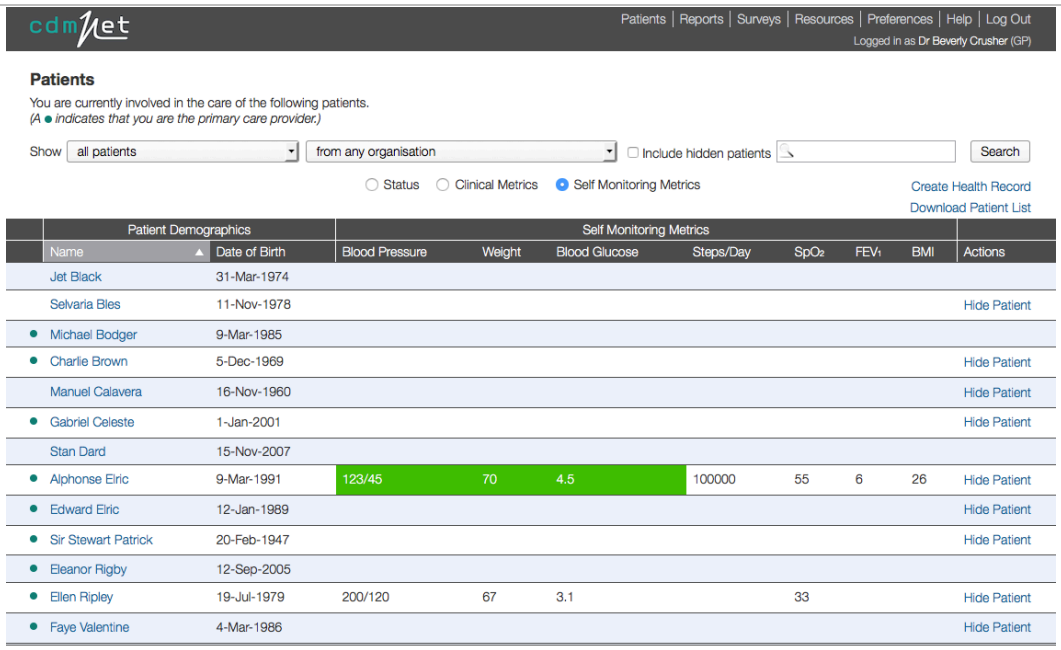


Figure 8. Self Monitoring Metrics View of Patient List

The columns in the Self Monitoring Metrics view reflect the measurements entered in the Self Monitoring section of the Measurements section of a patient's health record (see Chapter 4.2.4 Measurements Page — Self Monitoring measurements can be entered by the patient, or by a provider on behalf of the patient).

If you cannot find the patient you are looking for immediately on the list, you can search for them using the search box provided.

To search for patients, you can enter a first name, last name, cdmNet Number or Medicare Number. For example, if the only information you had about a patient was a surname, such as 'Farnsworth', you could type 'Farnsworth in the search box and among the results returned you would find the patient, Hubert Farnsworth.

Click Search without entering anything in the search box to display all listed patients.

Click Download Patient List to export a copy of your patient list as a CSV file based on the current filters and sort column. You can import this file into a spreadsheet or database application such as Excel or Numbers.

Click Create Health Record to create a patient whose health record does not exist on your clinical desktop software (Best Practice, Zedmed, Monet or MD3). Fill in the patient's details accordingly.

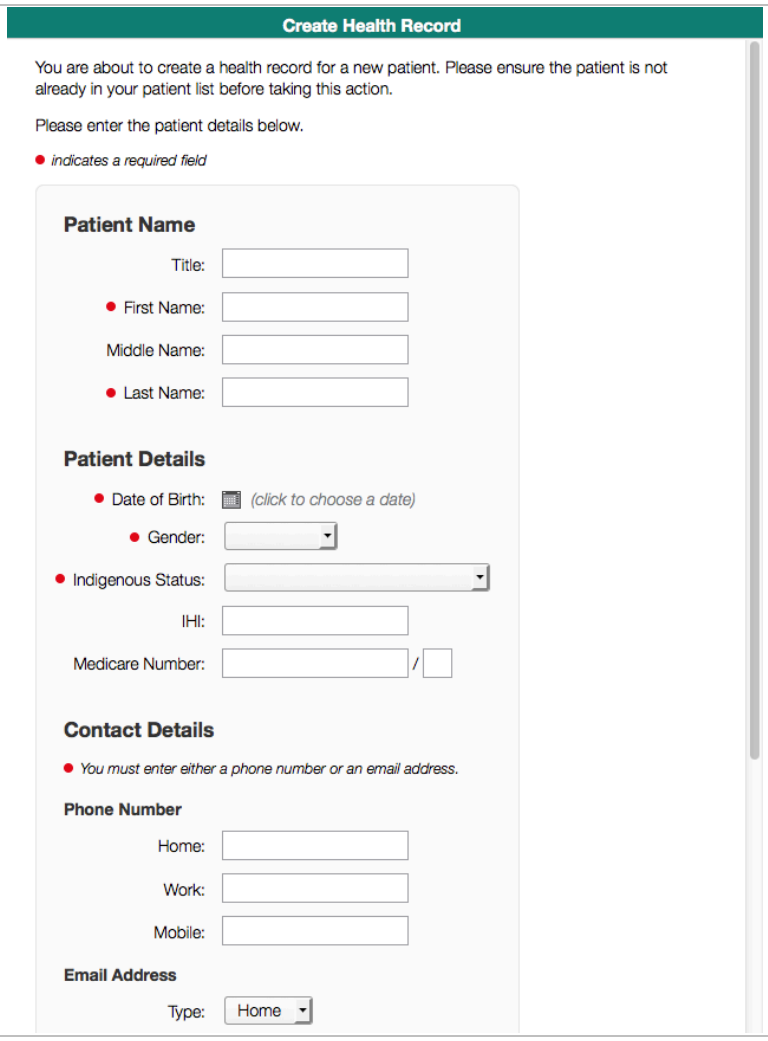


Figure 9. Create Health Record

Once you have completed the patient's details you can then proceed to obtain and confirm the patient's consent to share their health record (selecting a Primary Care Provider for the Patient if you are a Care Plan Creator). (See also Chapter 4.1 Creating a Patient's Health Record.)

A green dot to the left of a patient's name indicates that you are that patient's PCP. Clicking Show Primary Care Provider Patients Only displays the patients for whom you are the PCP. Depending on your role, you may be able to change a patient's PCP on the patient's health record if you wish (see Chapter 4.2.2.2 Changing a Patient's Primary Care Provider).

A small number in red next to a patient's name indicates whether any Progress Notes have been added since you last viewed the patient's health record (see Chapter 4.2.11 Progress Notes Page).

If you are assigned to some patients indirectly (for example, as a member of an organisation or a care plan creator), you can click Show Assigned Patients to view only patients to whom you are assigned.

If you are logging in to cdmNet for the first time, you may not have any patients. This may be because you have not uploaded any patient information from cdmNet Desktop, or you may not yet have been assigned to any patients by a PCP.

If you cannot find a patient's name, this could mean one of two things:

1. If you are a PCP or a CPC, you need to upload the patient's details from your clinical desktop software using cdmNet Desktop. (see the cdmNet Desktop Guide, available at **cdm.net.au/help/guides**.
2. Otherwise, the patient's PCP has not added you as a member of the patient's care team. Contact the PCP and ask them to assign you to a task on the patient's care plan.

The actions column appears if there are any actions that you can perform. For more information about these actions, see:

- Leave Care Team, (Chapter 9.5.2 Leaving the Care Team);
- Sign Documents (Chapter 9.5.1 Signing Documents); and
- Hide Patient (see below).

You can hide patients you no longer wish to see in the list by clicking the Hide Patient action in the Actions column. Hidden patients are only hidden for you; other providers can continue to access them normally. You can choose to unhide patients by clicking Unhide Patient (available when the 'Include hidden patients' box is ticked).

Clicking a patient's name displays the patient's health record (see Chapter 4.2 Patient Health Record). For Primary Care Providers and Care Plan Creators, if you have not yet created a health record for this patient, clicking their name displays the create health record page (see Chapter 4.1 Creating a Patient's Health Record).

4.1 Creating a Patient's Health Record

When you want to create a health record for a patient, you can upload their medical history and clinical information from your clinical desktop software (Best Practice, Zedmed, Monet or MD3) to cdmNet, using cdmNet Desktop (see the cdmNet Desktop Guide, available at **cdm.net.au/help/guides**). cdmNet displays the following page.

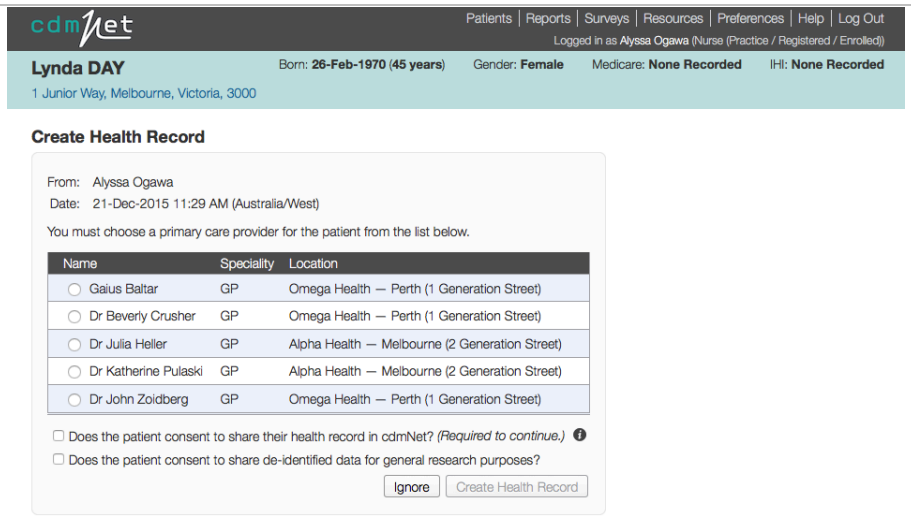


Figure 10. Health Record Creation

If you are a Care Plan Creator uploading a patient record onto cdmNet, you are prompted to select a Primary Care Provider.

You must obtain the patient's consent to share their health record in order to continue (unless they are a Test Patient).

Once you have created the patient's health record, the patient receives a notification from cdmNet with a username and temporary password they can use to log in to cdmNet.

(While the health record request is waiting for you to accept it, if someone else uploads the same patient's health record to cdmNet, the other person's request overrides the existing request and they are able to accept it. This could happen when two practice nurses from the same practice independently upload health records for the same patient, for example.)

4.1.1 Test Patients

By default, the 'Is the patient a test patient?' box is ticked. Leaving this box ticked means that the patient is marked as a Test Patient. This means that notifications will not be sent to the care team linked to the patient.

Marking patients as test patients is recommended for testing and training purposes, particularly if you are new to cdmNet. Once you have marked a patient as a test patient, you cannot turn them back into a normal patient. (However, you can always delete that test patient and upload the patient record onto cdmNet again if you created a test patient in error for a real patient.) You can turn off the test patient option in your Preferences (see Chapter 7.1 Account Details).

If you marked a patient as a Test Patient, cdmNet indicates this on the patient's health record with the following red bar, with the option of deleting the patient.

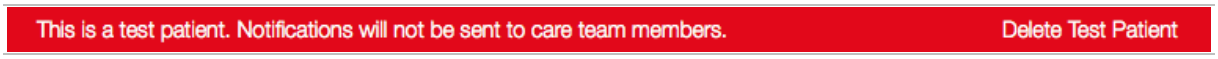


Figure 11. Test Patient Marker

4.2 Patient Health Record

When viewing the health record for a patient who does not have a care plan, the main green navigation bar contains several sections to choose from. They are:

- Overview;
- Contacts;
- Health Summary;
- Measurements;
- Planning;
- Care Team;
- Referrals;
- Documents;
- Assessments;
- Reports;
- Progress Notes; and
- Education.

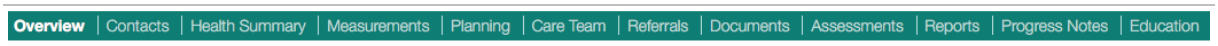


Figure 12. Patient Navigation Bar

Clicking a patient's name in your patient list to view their health record automatically opens the Overview section.

If a patient does not yet have a care plan, Primary Care Providers and Care Plan Creators can click Create Care Plan to initiate one (see Chapter 9 Creating Care Plans).

4.2.1 Overview Page

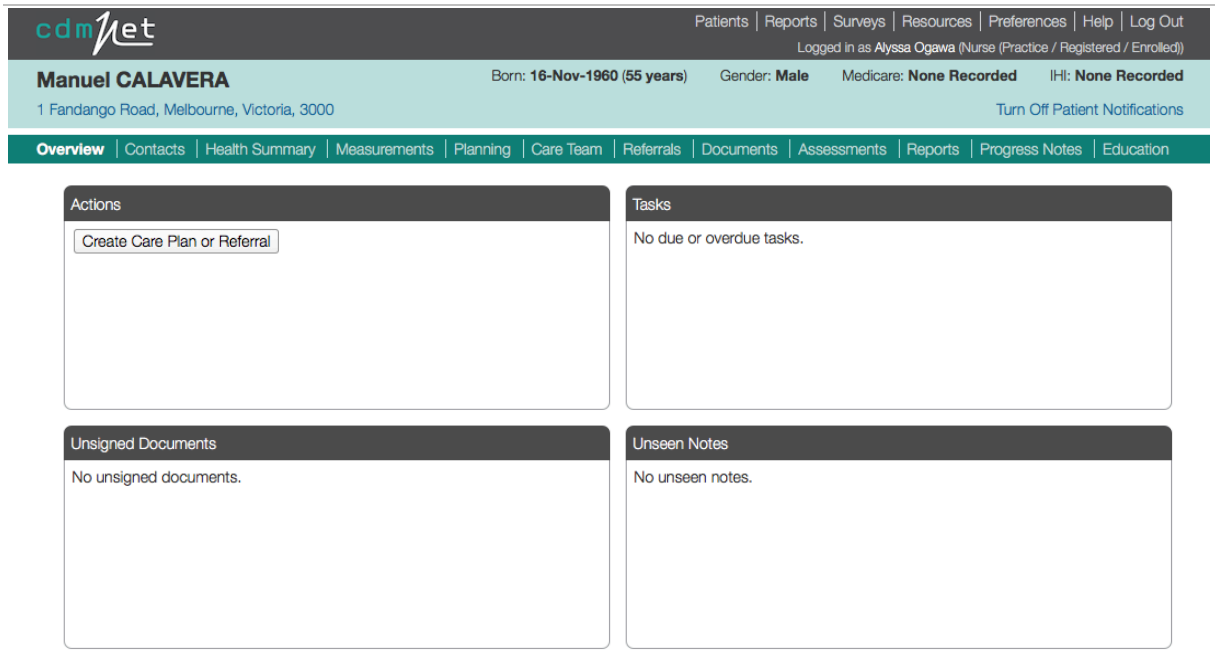


Figure 13. New Patient Health Record – Overview Page

The Overview page outlines the context-relevant information pertaining to a patient's health record in 'widgets'.

The Actions widget displays actions you can perform, including creating and approving care plans and documents, and recording appointments.

The Tasks widget displays tasks assigned to you on the patient's care plan that are due (or overdue).

The Unsigned Documents widget displays a list of documents related to a patient's cdmNet care plan that have not been signed. You can electronically sign documents from this widget when the appropriate button appears in the widget.

The Unseen Notes widget displays a basic summary of any notes that other care team members (or the patient) have entered since you last visited the Progress Notes page (see Chapter 4.2.11 Progress Notes Page).

You can rearrange the widget positions into your preferred order by dragging their title bars.

4.2.2 Contacts Page

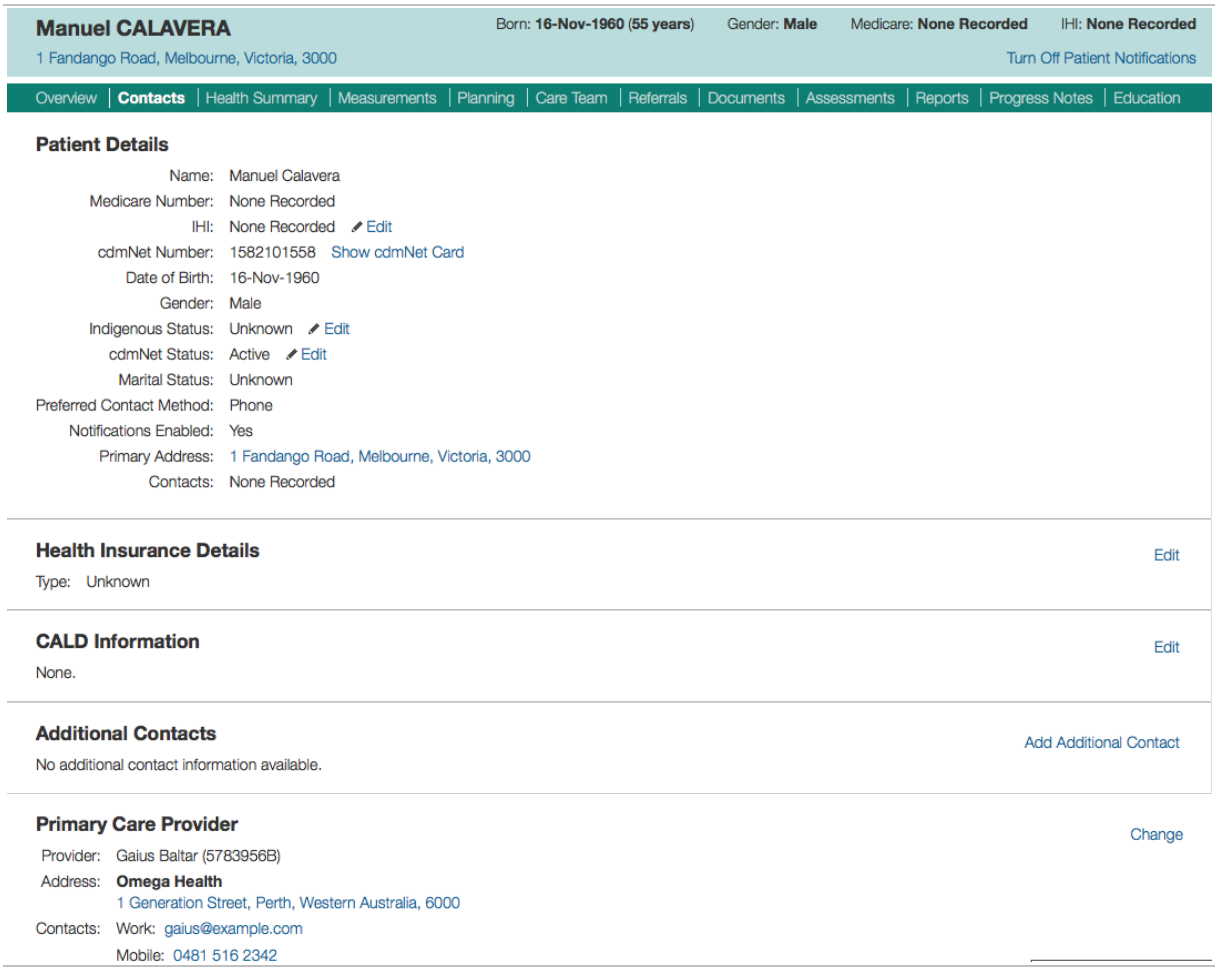


Figure 14. New Patient Health Record – Contacts Page

On the Contacts page Primary Care Providers and Care Plan Creators (only) can:

- Turn On/Off Patient Notifications (whether the patient displayed receives notifications from cdmNet about their care plan – this is available on all pages);
- Hide (or unhide) the patient (this action is available to all providers, on all pages);
- Edit the IHI of the patient;
- View the patient's cdmNet Number and Card (see Chapter 4.2.2.1 A Patient's cdmNet Number and Card);
- Edit indigenous status; (Aboriginal or Torres Strait Islander);
- Edit the patient's cdmNet status (Active, Discontinued or Deceased);
- Edit the patient's health insurance details;
- Edit the patient's CALD (Culturally and Linguistically Diverse) information;

- Add, Edit or Remove a patient's Additional Contacts (multiple additional contacts are allowed); and
- Change the patient's Primary Care Provider (see Chapter 4.2.2.2 Changing a Patient's Primary Care Provider).

When viewing the health record for a patient who has a care plan, this page also lists the Care Team Details.

4.2.2.1 A Patient's cdmNet Number and Card

The 'cdmNet Number' is a unique number identifying the patient's record within cdmNet. Click View cdmNet Card to display a printable card containing this number and a barcode, for use in conjunction with third-party systems that integrate with cdmNet.

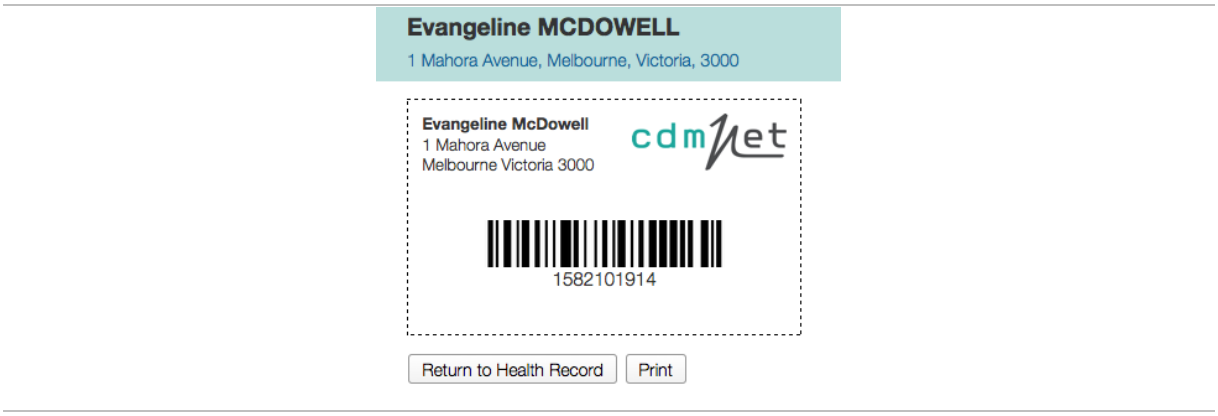


Figure 15. A Patient's cdmNet Number and Card

4.2.2.2 Changing a Patient's Primary Care Provider

To change a patient's Primary Care Provider, click Change Primary Care Provider. cdmNet displays the following page.

Figure 16. Change a Patient's Primary Care Provider Page

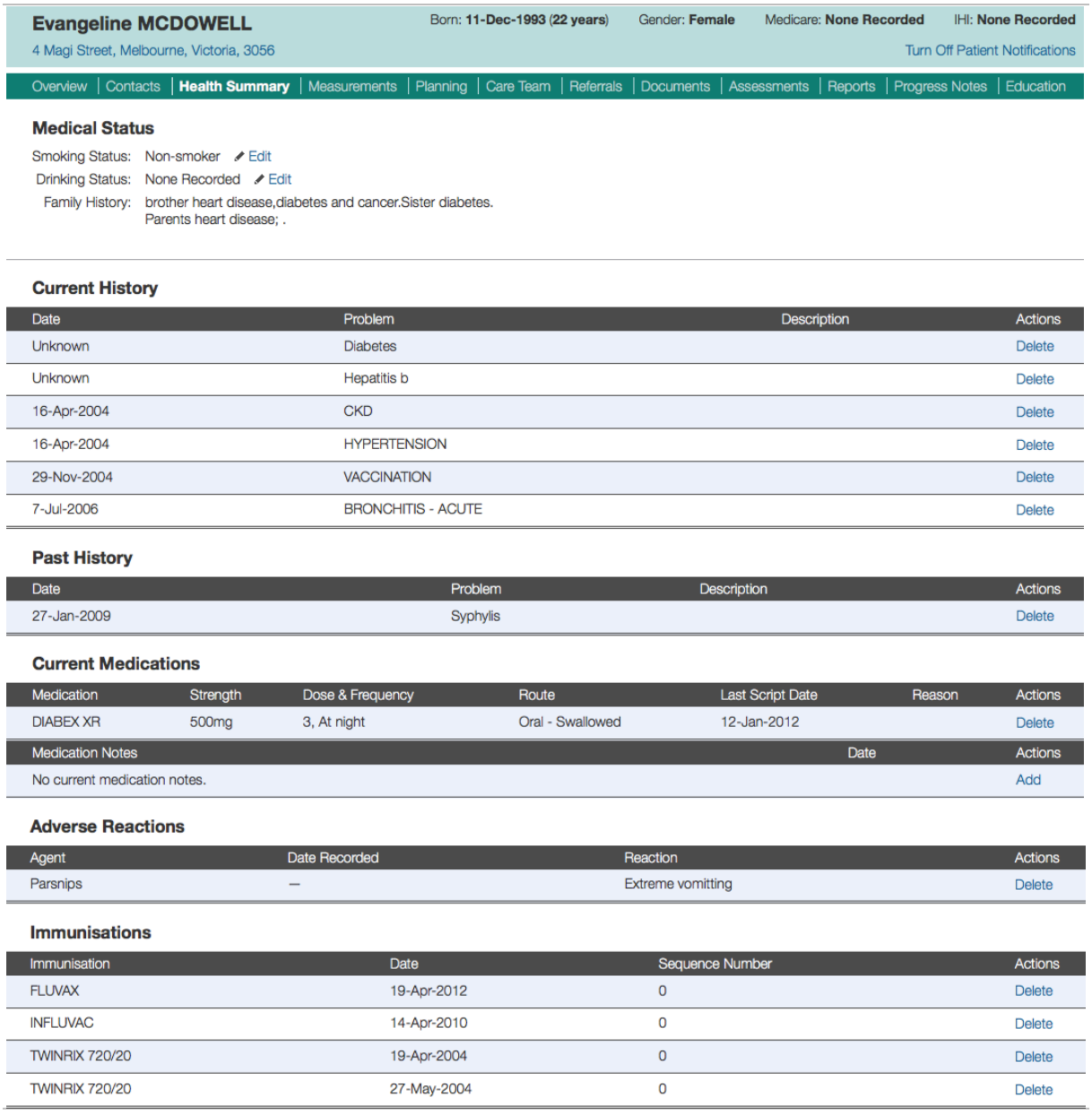
You can search for the Primary Care Provider by name, city and postcode.

You can view up to 300 results per page by clicking the drop down menu to the right of the page.

If you would like to reassign all tasks on the patient's care plan to the preferred providers of the new Primary Care Provider, tick the 'Replace all care team members on this care plan with the selected provider's preferred providers.' box before clicking Assign.

4.2.3 Health Summary Page

A patient's health summary page contains the information uploaded from the Primary Care Provider's or Care Plan Creator's clinical desktop software (Best Practice or MD3).



Evangeline MCDOWELL Born: **11-Dec-1993 (22 years)** Gender: **Female** Medicare: **None Recorded** IHI: **None Recorded**

4 Magi Street, Melbourne, Victoria, 3056 Turn Off Patient Notifications

Overview | Contacts | **Health Summary** | Measurements | Planning | Care Team | Referrals | Documents | Assessments | Reports | Progress Notes | Education

Medical Status

Smoking Status: Non-smoker Edit
Drinking Status: None Recorded Edit
Family History: brother heart disease,diabetes and cancer.Sister diabetes. Parents heart disease; .

Current History

Date	Problem	Description	Actions
Unknown	Diabetes		Delete
Unknown	Hepatitis b		Delete
16-Apr-2004	CKD		Delete
16-Apr-2004	HYPERTENSION		Delete
29-Nov-2004	VACCINATION		Delete
7-Jul-2006	BRONCHITIS - ACUTE		Delete

Past History

Date	Problem	Description	Actions
27-Jan-2009	Syphylis		Delete

Current Medications

Medication	Strength	Dose & Frequency	Route	Last Script Date	Reason	Actions
DIABEX XR	500mg	3, At night	Oral - Swallowed	12-Jan-2012		Delete

Medication Notes	Date	Actions
No current medication notes.		Add

Adverse Reactions

Agent	Date Recorded	Reaction	Actions
Parsnips	—	Extreme vomitting	Delete

Immunisations

Immunisation	Date	Sequence Number	Actions
FLUVAX	19-Apr-2012	0	Delete
INFLUVAC	14-Apr-2010	0	Delete
TWINRIX 720/20	19-Apr-2004	0	Delete
TWINRIX 720/20	27-May-2004	0	Delete

Figure 17. Patient Health Summary Page

On a patient's Health Summary Page, Primary Care Providers and Care Plan Creators (only) can:

- Edit a patient's Smoking Status (Smoker, Ex-smoker or Non-smoker);
- Edit a patient's Drinking Status (Drinker or Non-drinker);

- Delete items from a patient's Current History;
- Delete items from a patient's Past History;
- Delete items from a patient's Current Medications;
- Edit Medication Notes‡ about a patient's Current Medications;
- Delete items from a patient's Adverse Reactions; and
- Delete items from a patient's Immunisations.

Any data that is relevant to this page is uploaded from your clinical desktop software when the patient data is uploaded for the first time and any subsequent new data is uploaded where appropriate. The data on this page affects generation of goals and tasks upon care plan creation. Anything you subsequently change here (such as deletions) will not affect the care plan unless you rebuild it. Anything you delete will not affect patient data on your clinical desktop software.

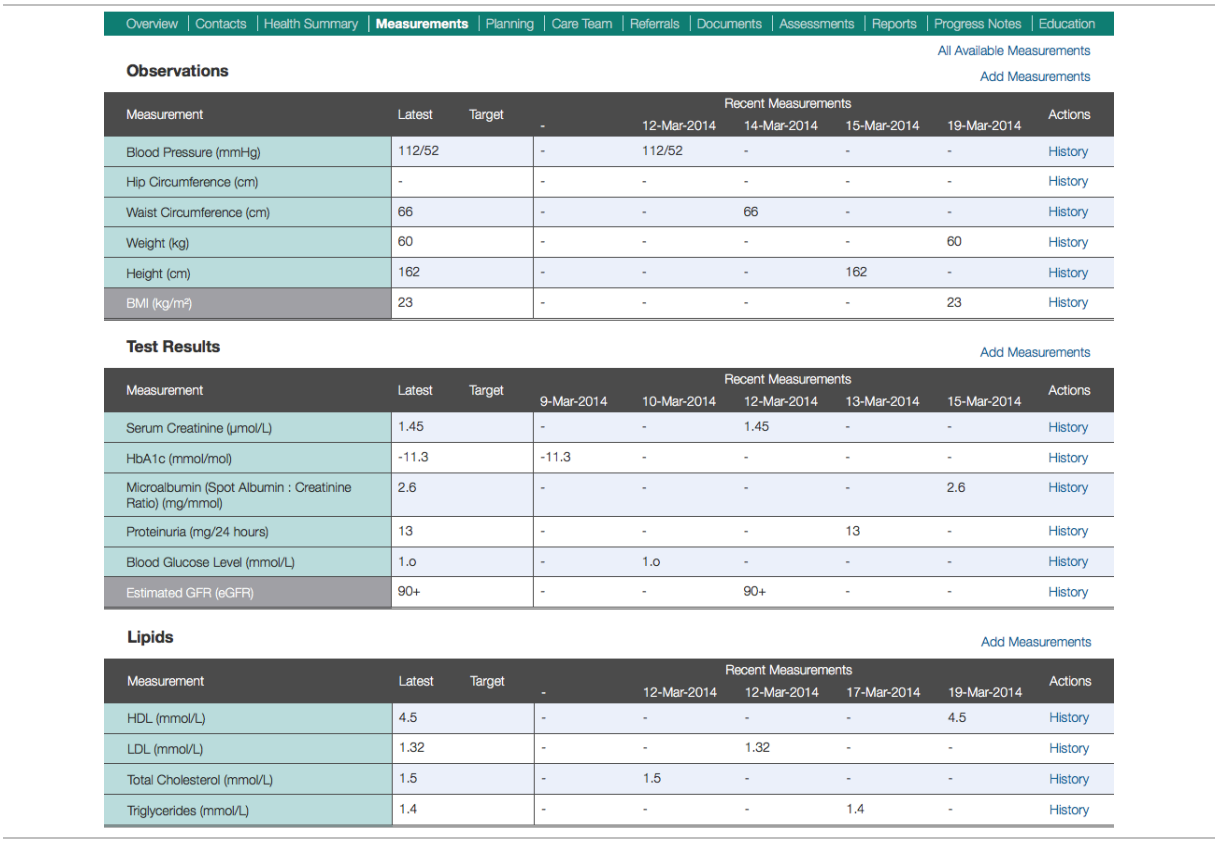
‡ Note that Medication Notes are different from the Progress Notes section (see Chapter 4.2.11 Progress Notes Page)

4.2.4 Measurements Page

A patient's measurements page contains information about the patient's clinical measurement history and how it relates to their care plan.

There are five main categories of measurements. They are:

- Observations;
- Test Results;
- Lipids;
- Self Monitoring; and
- Risk Calculations.



Overview | Contacts | Health Summary | **Measurements** | Planning | Care Team | Referrals | Documents | Assessments | Reports | Progress Notes | Education

All Available Measurements

Observations

Add Measurements

Measurement	Latest	Target	Recent Measurements -	12-Mar-2014	14-Mar-2014	15-Mar-2014	19-Mar-2014	Actions
Blood Pressure (mmHg)	112/52		-	112/52	-	-	-	History
Hip Circumference (cm)	-		-	-	-	-	-	History
Waist Circumference (cm)	66		-	-	66	-	-	History
Weight (kg)	60		-	-	-	-	60	History
Height (cm)	162		-	-	-	162	-	History
BMI (kg/m²)	23		-	-	-	-	23	History

Test Results

Add Measurements

Measurement	Latest	Target	Recent Measurements 9-Mar-2014	10-Mar-2014	12-Mar-2014	13-Mar-2014	15-Mar-2014	Actions
Serum Creatinine (µmol/L)	1.45		-	-	1.45	-	-	History
HbA1c (mmol/mol)	-11.3		-11.3	-	-	-	-	History
Microalbumin (Spot Albumin : Creatinine Ratio) (mg/mmol)	2.6		-	-	-	-	2.6	History
Proteinuria (mg/24 hours)	13		-	-	-	13	-	History
Blood Glucose Level (mmol/L)	1.o		-	1.o	-	-	-	History
Estimated GFR (eGFR)	90+		-	-	90+	-	-	History

Lipids

Add Measurements

Measurement	Latest	Target	Recent Measurements -	12-Mar-2014	12-Mar-2014	17-Mar-2014	19-Mar-2014	Actions
HDL (mmol/L)	4.5		-	-	-	-	4.5	History
LDL (mmol/L)	1.32		-	-	1.32	-	-	History
Total Cholesterol (mmol/L)	1.5		-	1.5	-	-	-	History
Triglycerides (mmol/L)	1.4		-	-	-	1.4	-	History

Figure 18. Measurements Summary Page

Targets only appear on this page if the patient has a care plan. The main point of the measurements page is to keep track of the history of measurements and review how well the patient is progressing to achieve the targets.

On this page, all providers can:

- Add Measurements to each category (see Chapter 4.2.4.1 Adding Measurements); and

- Click History in the Actions column to add a new measurement to a particular measurement type (see Chapter 4.2.4.2 History).

If the PCP or CPC had any of the relevant data for a particular measurement type on their clinical desktop software (Best Practice or MD3), you should find it that it has been uploaded into the appropriate fields in the Measurements Page.

The Self Monitoring category is primarily for patients who wish to enter measurements they took themselves (for example, readings from a home blood sugar level monitor). However, as a provider, you can also enter measurements on their behalf if they are not confident or comfortable with doing it themselves. You can see who entered particular measurements by hovering your mouse pointer over a measurement value to display such information in a 'tooltip'.

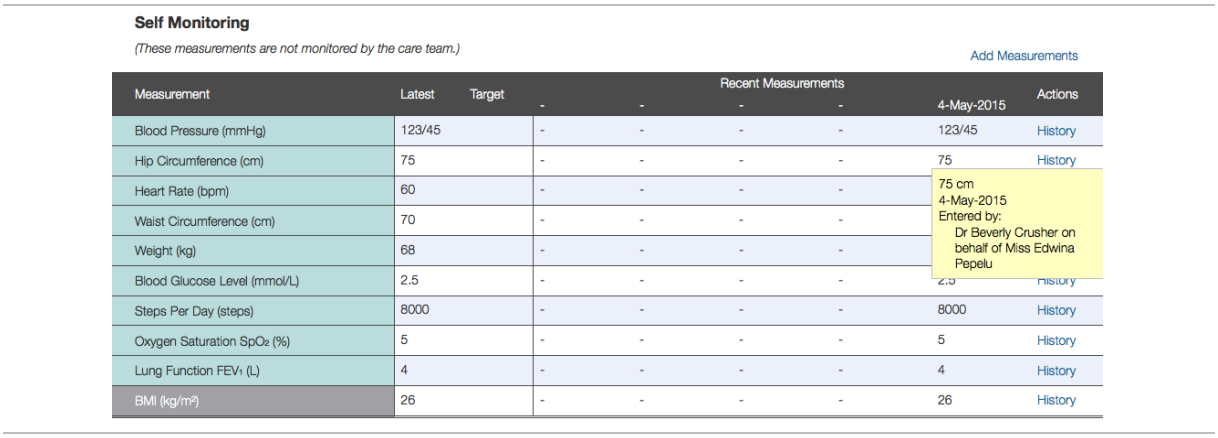


Figure 19. A Tooltip Displaying Measurement Value Information

4.2.4.1 Adding Measurements

To add new measurements to a category, click the Add Measurements link to the right of the category. cdmNet displays a screen like the following, where you can add the appropriate information accordingly.

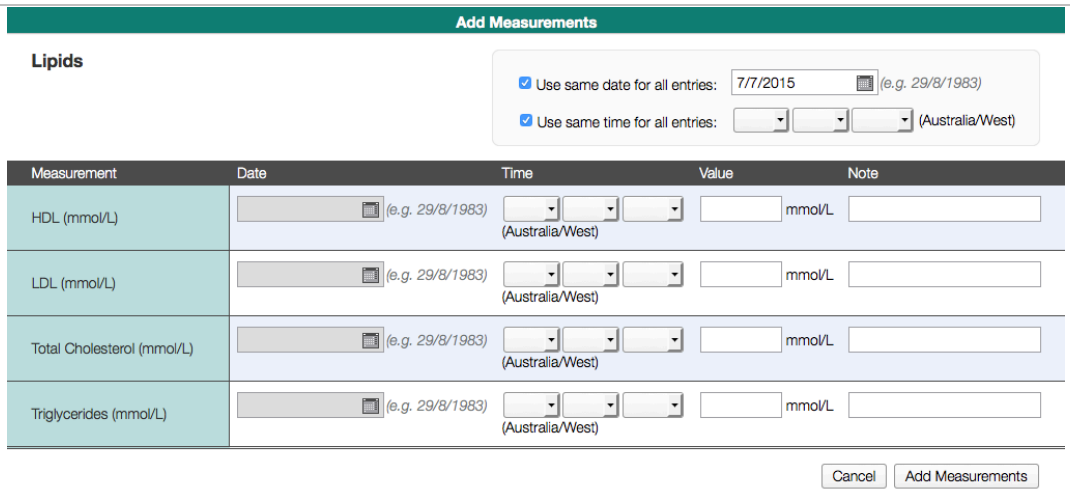


Figure 20. An Example of an Adding New Measurements to Categories Page

4.2.4.2 History

The History screen contains more history of measurement values than is displayed on the main Measurements Page.

Clicking History in the Actions column of a measurement category also allows you to enter measurement values of the particular measurement type you selected.

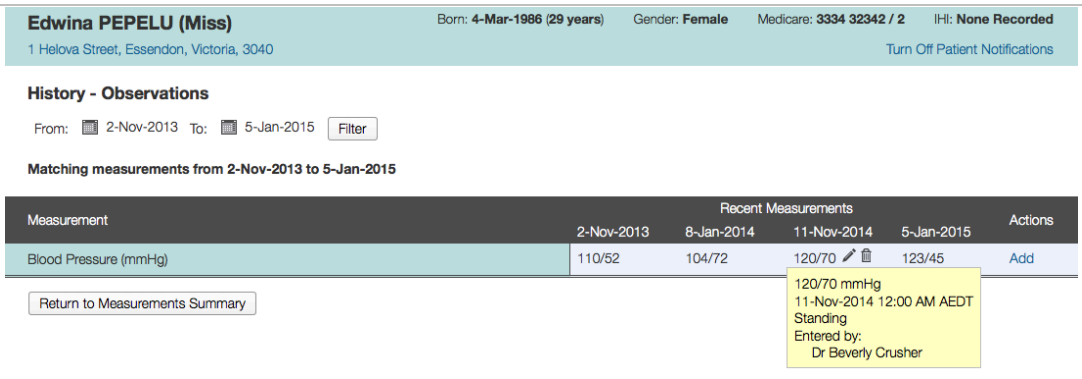


Figure 21. Add New History Measurement

In the above example of weight history, you can see three historical measurements for the Date Range selected. Hover your mouse over a measurement to view the pencil icon (to edit it) or the rubbish bin icon (to delete it). Figure 21 shows the middle measurement with a tooltip displaying more information about the measurement value.

To add a new measurement value on the same page, click Add New under the Actions column. cdmNet then displays the following.

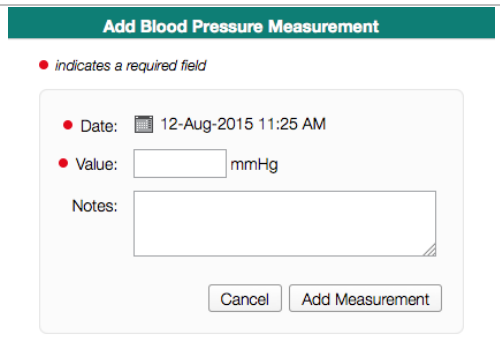


Figure 22. Add Measurement Value

You can add the appropriate Value and any Notes in the boxes provided. Any notes you enter in this page will only be displayed in the tooltip on the Measurements page when you hover your mouse over that particular measurement value; they will not appear on the patient's Progress Notes page.

4.2.4.3 All Available Measurements

Click the All Available Measurements link at the top right to see all available measurement information in cdmNet for a patient (including those not handled in cdmNet). By default, the page displays the past year's worth of measurements for a patient.

Edwina PEPELU (Miss) Born: **4-Mar-1986 (29 years)** Gender: **Female** Medicare: **3334 32342 / 2** IHI: **None Recorded**
1 Helova Street, Essendon, Victoria, 3040 Turn Off Patient Notifications

All Available Measurements

From: 15-Jul-2014 To: 15-Jul-2015 View For Date Range

Date	Name	Value	Units
4-May-2015 12:00 AM	Blood Glucose Level	2.5	mmol/L
4-May-2015 12:00 AM	Blood Pressure	123/45	mmHg
4-May-2015 12:00 AM	Heart Rate	60	bpm
4-May-2015 12:00 AM	Hip Circumference	75	cm
4-May-2015 12:00 AM	Lung Function FEV_1	4	L
4-May-2015 12:00 AM	Oxygen Saturation SpO_2	5	%
4-May-2015 12:00 AM	Steps Per Day	8000	steps
4-May-2015 12:00 AM	Waist Circumference	70	cm
4-May-2015 12:00 AM	Weight	68	kg
5-Jan-2015 4:21 PM	Blood Pressure	123/45	mmHg
11-Nov-2014 12:00 AM	Blood Pressure	120/70	mmHg

Return to Measurements Summary

Figure 23. All Available Measurements

4.2.5 Planning Page

The purpose of the Planning page is to set tasks and goals, tailoring them to suit the individual patient in order for them to manage their condition(s).

The content and composition of a patient's planning page varies depending on the condition(s) they have and your association with that patient.

There is a general template of planning, consisting of several main sections. They include:

- Main Objective;
- Disease Condition Management;
- Lifestyle Factors Management;
- General;
- Lifestyle;
- Biomedical;
- Psychosocial;
- Complications;
- Medications;
- Preventive Health;
- Infectious Diseases; and
- Mental Health Support.

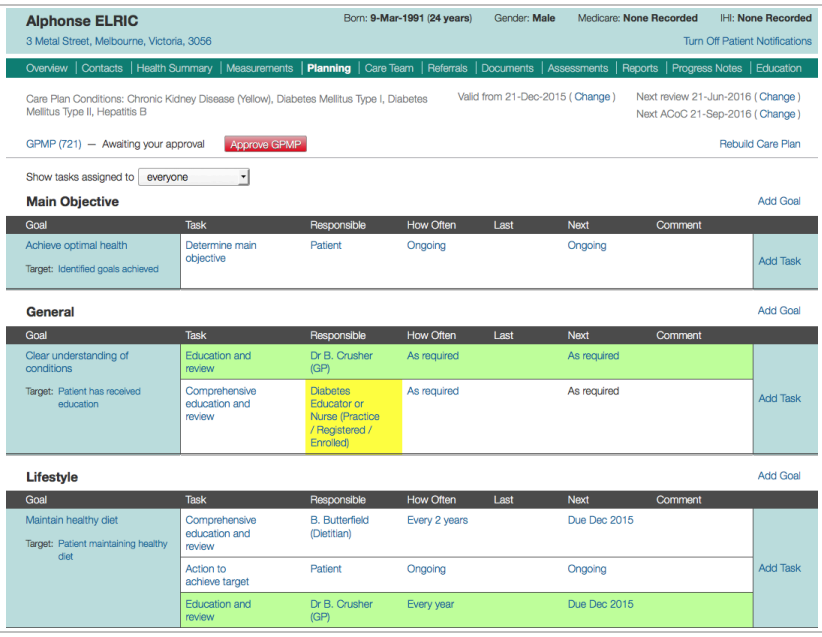


Figure 24. Planning Page

Using the filter at the top, you can change the Planning page to display:

- Tasks assigned to you;
- Tasks assigned to your organisations;
- Tasks assigned to the Primary Care Provider;
- Tasks assigned to other care team members;
- Tasks assigned to the patient; and
- Tasks assigned to everyone.

By default, cdmNet displays all tasks in the care plan (this is the 'tasks assigned to everyone' option). If you change the filter to display another view, it applies for the particular patient you are viewing, until you move on to another patient or log out. cdmNet then changes the filter back to the default selection.

On this page, you can:

- Edit the Last time a task was undertaken; and
- Set the Next time a task will be undertaken.

(See Chapter 4.2.5.2 Creating and Editing Appointments)

In addition, PCPs and CPCs can:

- Add new goals;
- Add new tasks;
- Edit or set the responsible party for particular tasks;
- Edit or set the frequency of tasks; and
- Add comments about particular tasks.

(See Chapter 4.2.5.1 Adding, Editing and Deleting Goals and Tasks)

(For more information on the context in which you might do these things, see Chapter 9.2 Modifying Care Plans.)

Some goals may appear in a different planning group. For example, goals from Mental Health Support may appear in a separate planning group from the 'Main' planning group. If more than one planning group is available, cdmNet displays the planning groups immediately above the list of goals and tasks in the plan. When a separate planning group appears, click the name of the planning group to view and edit the goals and tasks in that group. cdmNet remembers which planning group you viewed most recently and takes you to the same group (if available) whenever you go to the Planning page.

(Note that planning groups currently only appear for some users, depending on speciality, the programs the patient is participating in and the medical conditions covered by the care plan.)

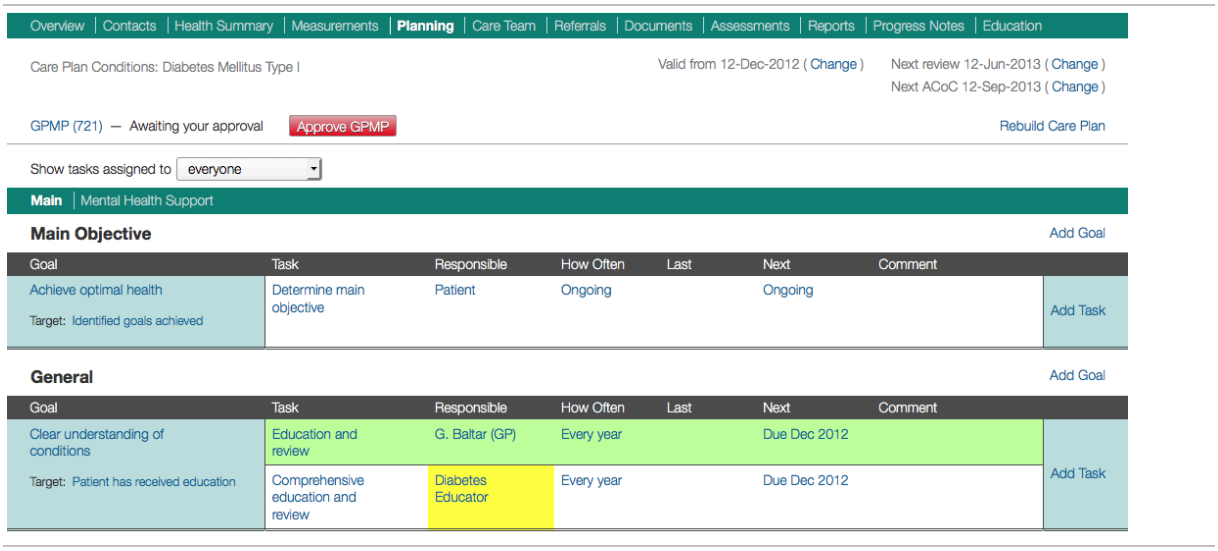


Figure 25. Planning Groups

Care Plans consist of goals (column on the left) and tasks to achieve them (Task column next to Goal column). There are providers responsible for seeing tasks through (Responsible column) and the frequency of the tasks to be undertaken.

Tasks	**Indicates**
Green	The task is your responsibility.
Yellow	Your attention may be required for this area, or you may need to check the information cdmNet has generated.
Red	There is a problem that needs resolution (for example, an overdue task).
Not highlighted	The task may be the patient's responsibility. Or, The task has already been assigned to another provider.

Note that only Primary Care Providers and Care Plan Creators can assign providers to tasks. Care Team Members cannot assign themselves to tasks, regardless of their speciality and association with a patient.

4.2.5.1 Adding, Editing and Deleting Goals and Tasks

This functionality is only available to PCPs and CPCs.

To add a new goal, click Add Goal to the right of the section title to which the goal applies.

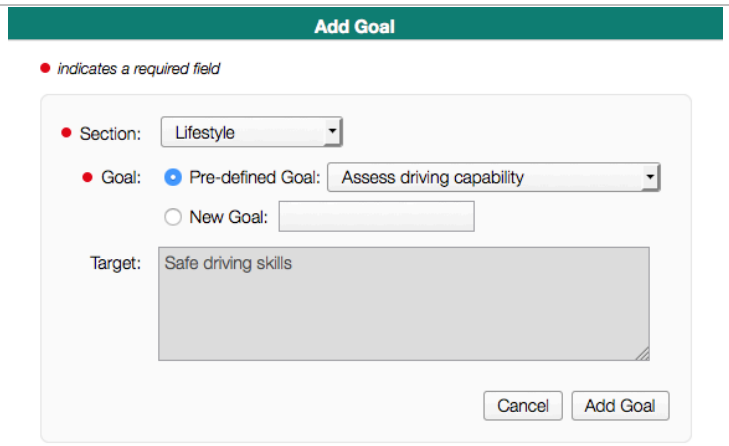


Figure 26. Adding a New Goal

To view all available pre-defined goals, select the All option from the section menu. You can add pre-defined goals that apply to the patient's conditions as well as goals that may apply to other conditions where you see fit.

You can add a custom goal if you cannot find an appropriate goal in the pre-defined goal list. To do this, click the New Goal radio button and fill in the appropriate details in the boxes provided.

You can add tasks to particular goals where you see fit by clicking Add Task in the appropriate goal row.

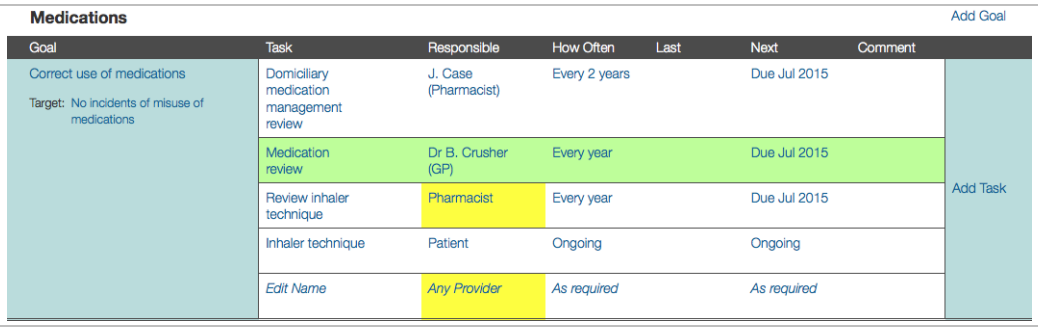


Figure 27. Adding a New Task

(In previous releases of cdmNet, adding tasks occurred in a separate screen. You can still use this method of adding tasks by holding down the Alt or Option key on your keyboard when you click Add Task.)

When you click Add Task, cdmNet adds a new 'provisional' task row into the goal. To edit the task name, click Edit Name. If there are pre-defined tasks available for the goal, a combo box (downward triangle) appears, from which you can select the pre-defined task you want. When you choose a pre-defined task, cdmNet automatically fills in the other information for that task, including assigning a provider from the Primary Care Provider's preferred providers (if applicable), setting the task's frequency and displaying the Next date.

If you want to add a custom task, type in the task's name rather than choosing a pre-defined option. If there are no pre-defined tasks available for the goal, the combo box (downward triangle) does not appear.

You can also edit tasks and goals by clicking the pencil icon in the appropriate cell. Clicking the pencil icon displays a separate screen where you can edit the task or goal in its entirety.

You can change the Display Name of the goal or task, which is used everywhere in cdmNet. In addition, the original goal or task name is shown on these edit screens: care team members and patients can see this original name in a 'tooltip' by hovering the mouse pointer over a task or goal name on the Planning section.

You can also delete tasks and goals from these screens by clicking the Delete Goal or Delete Task button.

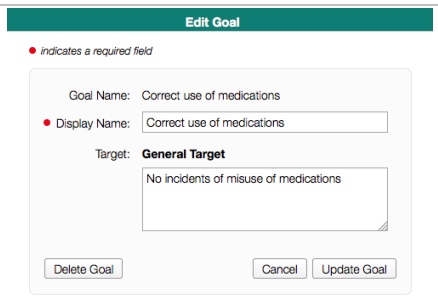


Figure 28. Editing a Goal

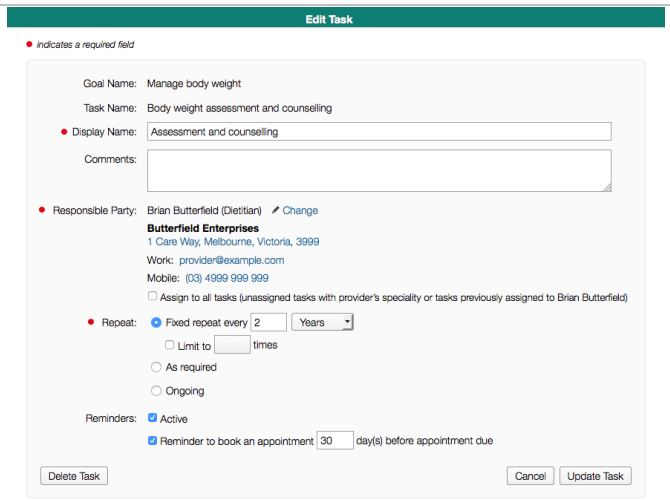


Figure 29. Editing a Task

If you only want to change the display name of a goal or task, clicking the name of the goal or task on the Planning section allows you to begin editing the goal or task inline rather than in a separate screen. Press the Return key or click outside the box

to save your changes. To cancel editing and discard your changes, press the Escape key.

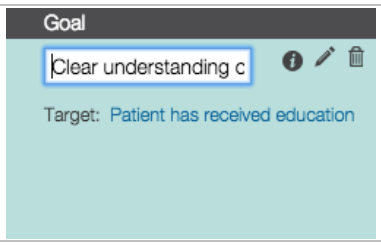


Figure 30. Editing a Goal Inline

Figure 31. Editing a Task Inline

To delete a goal or task, click the rubbish bin icon in the appropriate goal or task cell (or click the pencil icon to display the Edit screen and then click the Delete button).

Tasks require responsible parties assigned to them. To select a responsible party for a task click the downward triangle in the Responsible column for the appropriate task. Here, cdmNet displays a menu to allow you to select a responsible party. The options displayed in the menu depend on who is already assigned for the particular task. Where appropriate, from this menu, you can directly assign the task to the patient or the Primary Care Provider (usually the GP). From this menu, you can also assign a task to one of the top 5 preferred providers (who have the recommended speciality for the task) as per the Primary Care Provider's preferred providers.

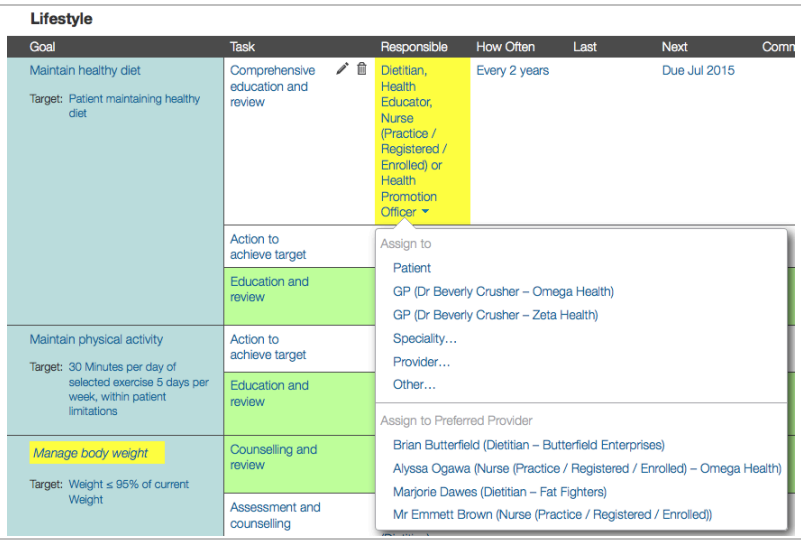


Figure 32. Edit Responsible Party Menu

Selecting Speciality… allows you to select a speciality for a task without having to select a specific individual or organisation. When you choose a single speciality, you can also record appointments and generate Allied Health Referral forms for that speciality (see Chapter 4.2.7 Referrals Page).

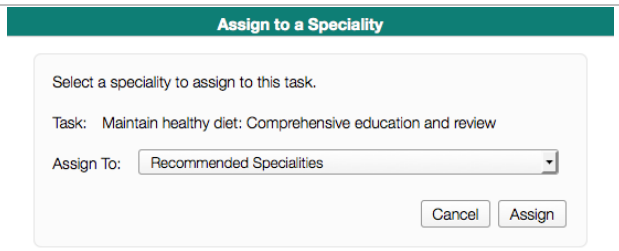


Figure 33. Assign to a Speciality

Selecting Provider… allows you to search for a provider within cdmNet to assign to the task.

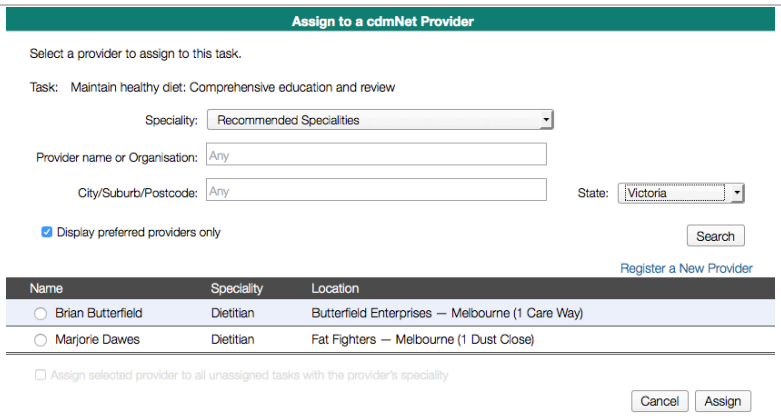


Figure 34. Assign to a cdmNet Provider

Ticking the 'Display preferred providers only' box restricts the search results to display the PCP's preferred providers only.

From here, you can also register a new provider on their behalf if you cannot find them in cdmNet. To do this, click Register a New Provider and fill in the appropriate details in the boxes provided (see Figure 66). As long as you are able to provide accurate contact information, the new provider should receive a notification with a username and temporary password with which they can use to log into cdmNet in future.

If there is a menu in the Speciality column, this indicates the organisation has members with different specialities; you need to choose one of these specialities to assign.

If there is a menu in the Location column, this indicates that the provider is a member of multiple organisations; you need to choose one of these organisations, as appropriate to the referral.

If a provider has the additional text '[organisation referral]' in the Location column, this indicates that the task would be assigned to the organisation as a whole, not the individual provider.

When you have selected the provider for a task, you can assign them to all tasks that the previous provider was assigned to, or assign them to unassigned tasks with that provider's speciality. You can do this by ticking the 'Assign to all tasks' box when it becomes available after you select a provider.

Selecting Other… from the menu allows you to search for a service provider (a provider whose speciality is not medical).

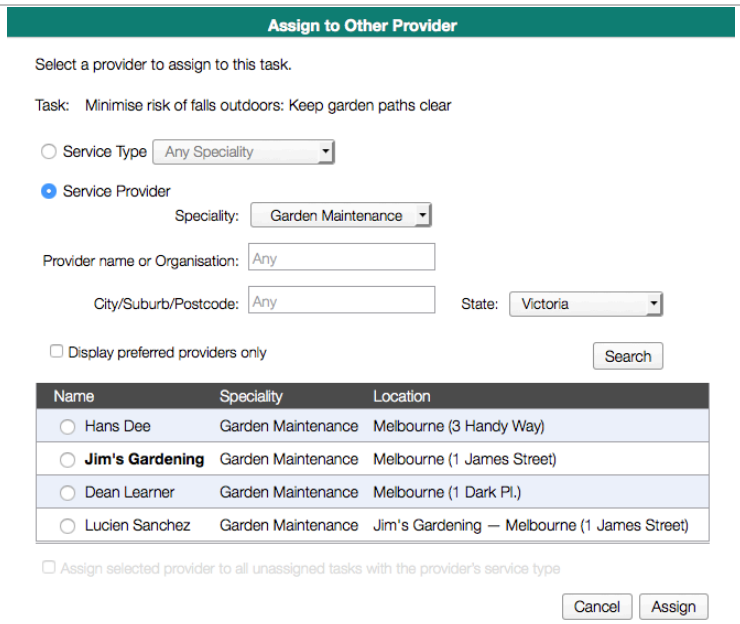


Figure 35. Assign to an Other Provider (Service Provider)

(This functionality works similarly to the Assign to Provider functionality described above.) Here, selecting Service Type and clicking Assign allows you to assign a type of service to the task, but not a specific service provider or organisation.

To select a specific service provider or organisation, select the Service Provider radio button and search accordingly.

Alternatively, having clicked the pencil icon next to a task name, you can choose to assign a speciality, the patient, the GP or either type of recommended speciality (provider or services provider) for a particular task by clicking the Change action next to the current assignee's name (see Figure 29).

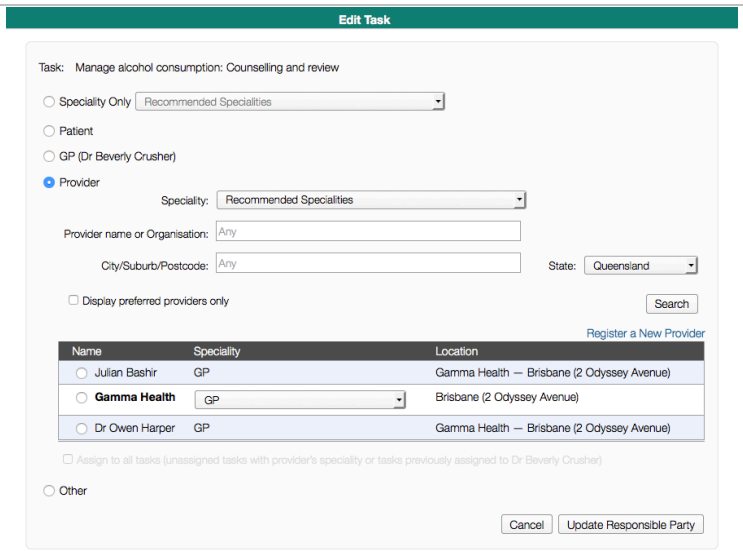


Figure 36. Edit Task

Select the Provider radio button to assign a provider or click the Other radio button to assign a service provider.

Tasks also require a set frequency. You can set the frequency when you add tasks and then alter them by clicking their frequency in the How Often column. You can also set a fixed frequency (days, weeks, months and years) and limit the repetitions by ticking the tick box. cdmNet calculates the number of times the repetitions occur when you set the fixed frequency and tick the box.

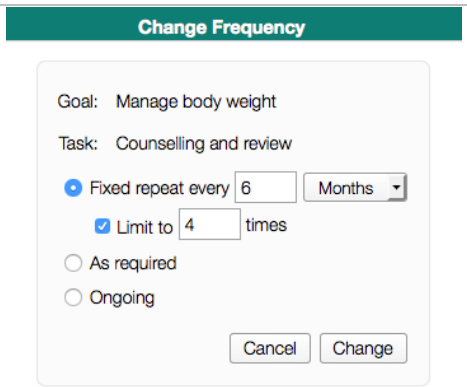


Figure 37. Edit Frequency of Task

4.2.5.2 Creating and Editing Appointments

You can change the next date without setting a specific appointment for when a task needs to be undertaken. Under the Next column, click the downward triangle beside the due date, and the options of changing the next date and adding

appointments (or adding measurements for measurement-related tasks in the Biomedical section) are displayed.

Figure 38. Change Next Date Menu

You can change the next date for a task up to five years in the future. When there is no specific party assigned to a task, you can only change the next date.

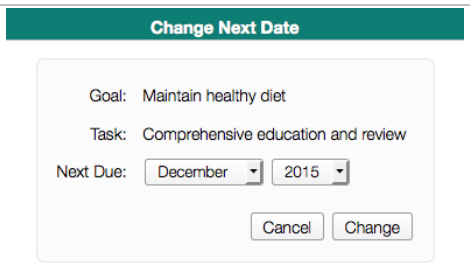


Figure 39. Change Next Date

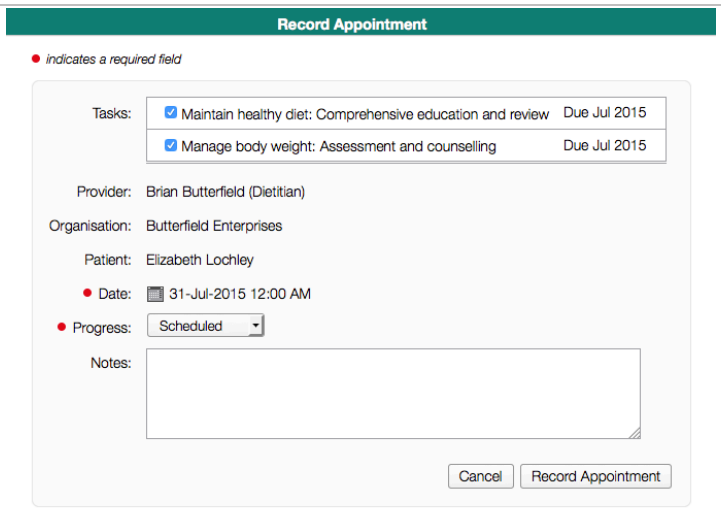


Figure 40. Record Appointment

Clicking the calendar icon next to Date displays a date and time calendar where you can set a specific date and time for appointments. You can also record appointments from the Overview Page.

4.2.5.3 Seeing Changes

After a GPMP has been approved, if any changes have been made to the care plan (for example, assigning a different provider to a task or changing a task's frequency), a pink change bar appears next to the modified area. Hover the mouse over the pink change bar to view information on a tooltip as to what the change was.

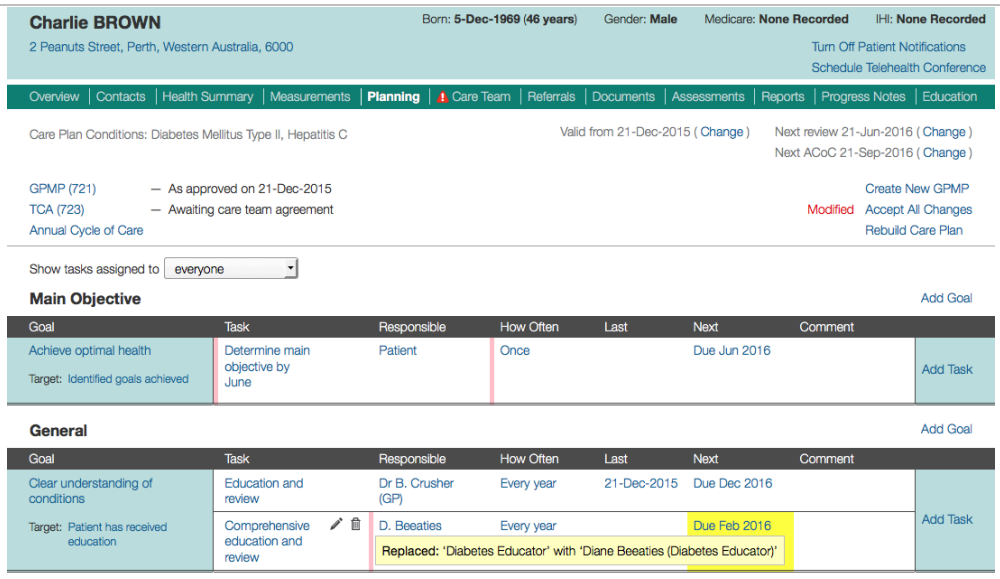


Figure 41. Responsible Party Modified

Any modifications made to a care plan will also be indicated by a red Modified mark on the top right of the page. The PCP or CPC can accept the modifications by clicking Accept All Changes at their discretion.

4.2.6 Care Team Page

This page contains the list of the Care Team members (individual providers and organisations) that are involved in a particular patient's care plan, including the Primary Care Provider at the top of the list.

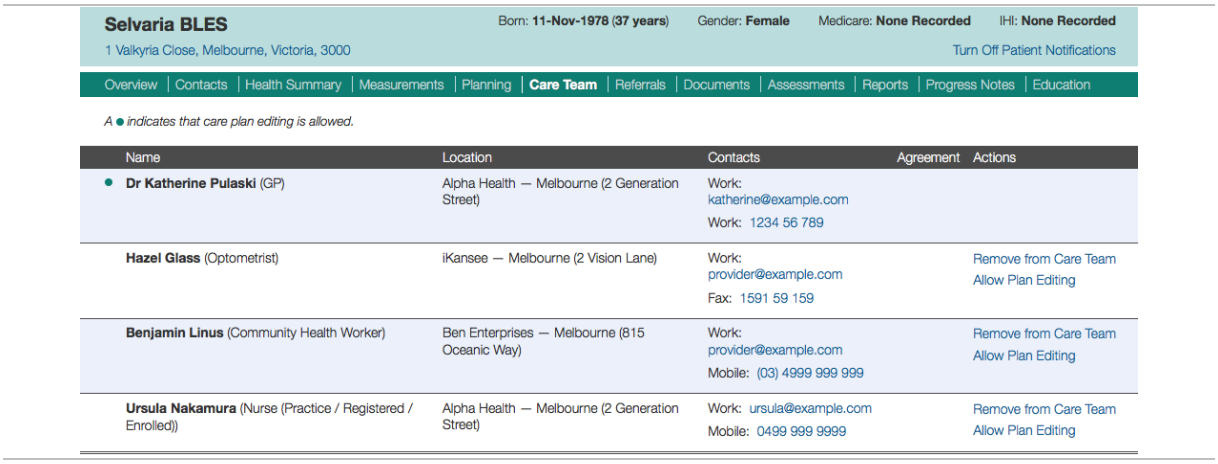


Figure 42. Care Team Page

On this page, you can:

- Click a care team member's email address to send them an email;
- Click a care team member's contact number to initiate a Skype call (if Skype is installed);
- Allow (or don't allow) a care team member to edit care plans; and
- Remove a care team member from the care team.

When you click Allow Plan Editing for a care team member, a green dot appears next to the care team member's name. Enabling a care team member to edit care plans means that they are able to edit a care plan in the same way that a Care Plan Creator can. Click Don't Allow Plan Editing if you no longer want that care team member to be able to edit care plans.

When a TCA has been distributed (see Chapter 9.5 Care Team TCA Agreements), the Care Team Members need to agree to participate. If/when they have, a grey thumbs-up icon appears next to their name.

As a PCP or CPC, you can add agreements from Care Team Members on their behalf, provided that you have consulted with them on the matter. To do this, click Add Agreement, and tick the box that confirms it.

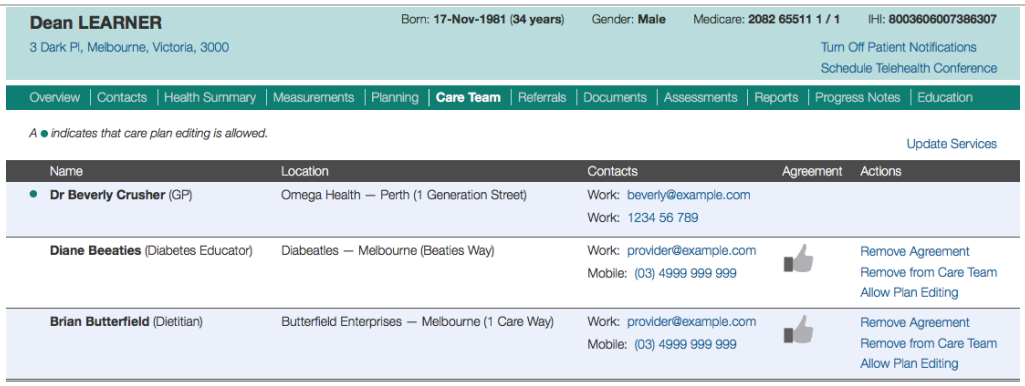


Figure 43. Care Team Page with Care Team Agreements

(Similarly, when a TCA Review is in progress, the Care Team members need to agree to it and as the PCP or CPC, you can add agreements on behalf of Care Team members. TCA Review agreements appear as a thumbs-up with a green tick above it.)

A Primary Care Provider or Care Plan Creator can click the Update Services action to edit the number of Allied Health Services provisionally allocated while a TCA is in progress.

4.2.7 Referrals Page

On the Referrals page, you can send formatted referrals to other individuals or organisations that are involved in a patient's care. (The care plan must be approved before you can create or send referrals.)

Click the Create Referral action on the right, select the type of referral when prompted and fill it in accordingly.

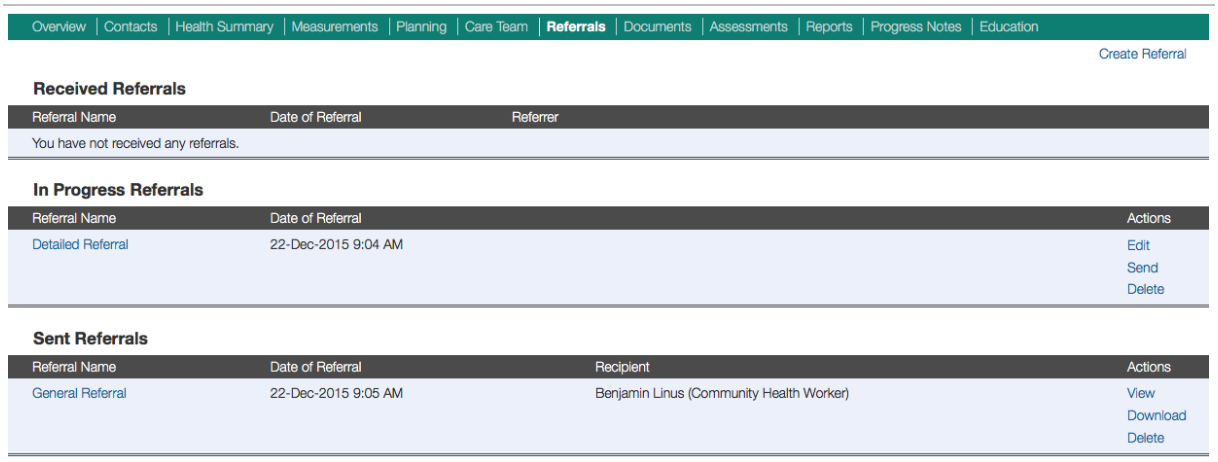


Figure 44. Referrals Page

Once you have completed the referral, you can send it to any member of the care team by clicking Send Referral and selecting the care team member to send it to.

Click Save Without Sending if you wish to save the referral and continue to edit it later. Otherwise, if you're ready to send it, click Send Referral when editing the referral, or use the Send action from the In Progress Referrals section on the Referrals page.

Sent referrals appear in your Sent Referrals section and timeline entries with the details of all sent referrals appear in the Progress Notes. (Note that all care team members can see the timeline entries, not just the sender and recipient.)

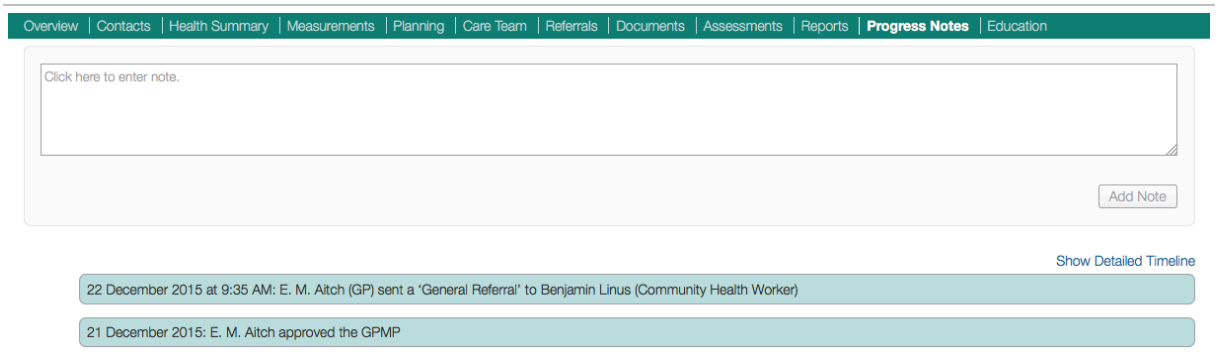


Figure 45. Progress Note Entry For Sent Referral

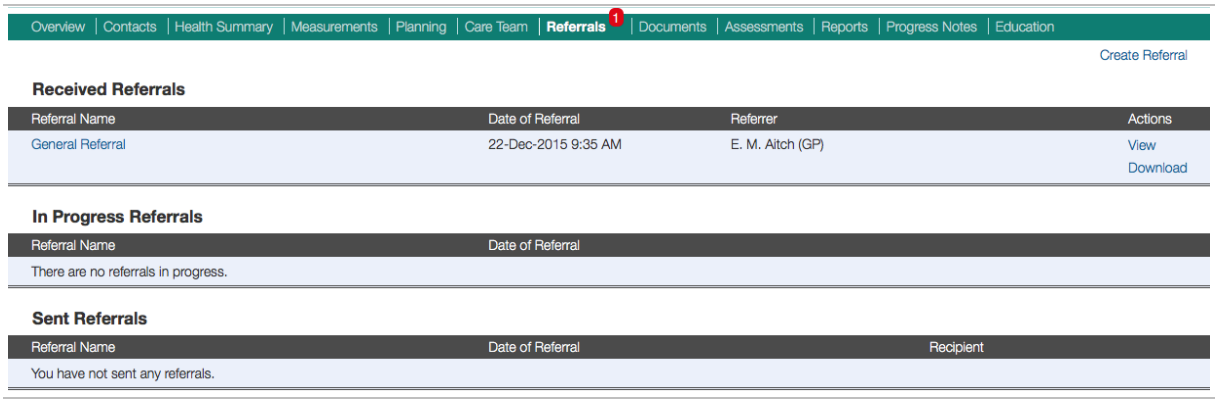


Figure 46. Received Referral

Received referrals appear in the Received Referrals section. There is also a notification badge to indicate that you have not yet viewed a received referral.

This badge also appears next to the patient's name on the patient list to indicate an unseen referral (see Figure 57 Patient List With Notification of New Progress Notes and Referral).

4.2.8 Documents Page

The Documents page has the following sections:

- Drafts;
- Current Care Plan;
- Approved Care Plans;
- Annual Cycles of Care;
- Supporting Documents; and
- Uploaded Documents.

Depending on the status of the patient's record, not all of these sections are shown all the time.

If the patient does not have a care plan, only the Uploaded Documents section appears.

If you wish to upload a document that you feel is relevant to a patient, clicking Upload Document allows you to select a document to upload onto a patient's health record. (Note that all other providers associated with a patient can also view any document you upload.)

You can also control who can see an uploaded document. When uploading a document, cdmNet pre-selects for the document to be visible to 'Everyone'. Select 'Specific people' and untick anybody who should not see the uploaded document. You can edit this list later if you want, by clicking the Edit action next to the document name in the Uploaded Documents section.

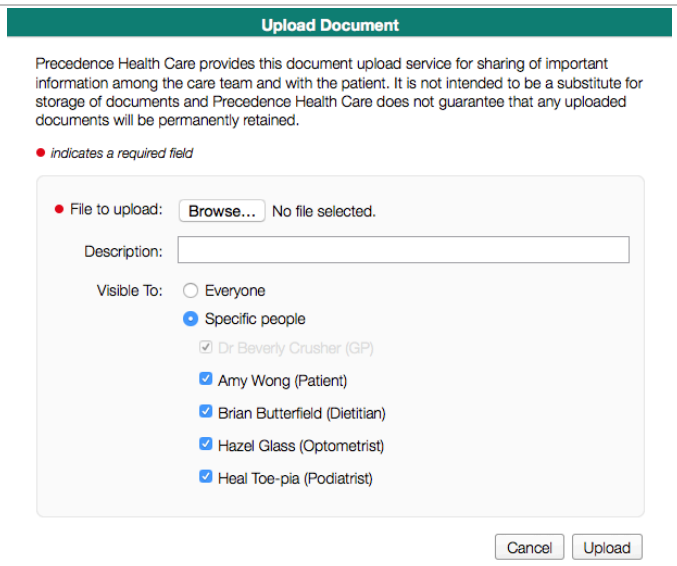


Figure 47. Editing Visibility of Uploaded Document

Figure 48. Documents Page of a Patient with No Care Plan

When you upload a document, an entry appears in the Progress Notes page, detailing the date, time and the description (if applicable). If you delete a document you uploaded, cdmNet prompts you for a reason for deleting the document and the Progress Notes entry displays this reason.

Clicking the file name in the File column opens a new window displaying the content of the document. You can also click View in the Actions column to view the document in a new window.

Clicking the description of the file in the Description column allows you to change the description of any document you uploaded.

You can download a document by clicking Download in the Actions column.

You can also delete any documents that you have uploaded by clicking Delete in the Actions column.

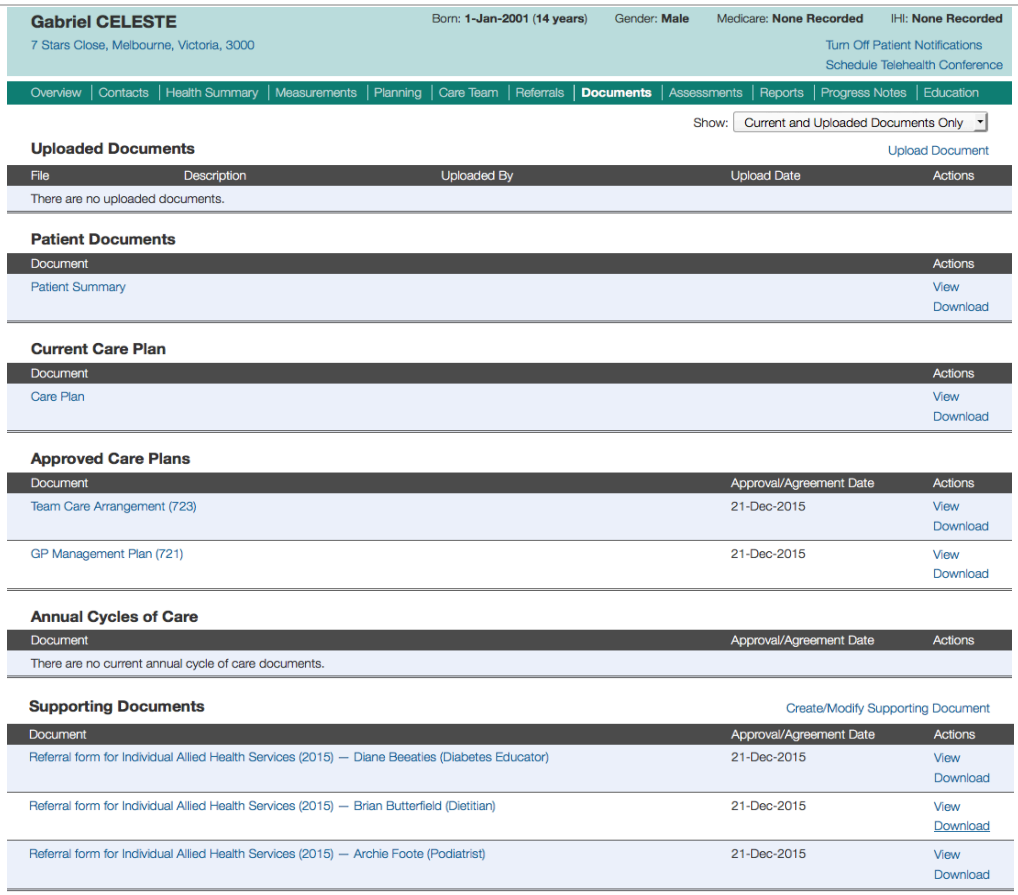


Figure 49. Patient With Care Plan Documents Page

cdmNet automatically generates documents that are relevant to the patient's care plan when appropriate. These include:

- Care Plans;
- Patient Summary;
- GP Management Plans (MBS item 721);
- Team Care Arrangements (MBS item 723);
- GP Management Plan Reviews (MBS item 732);
- Team Care Arrangement Reviews (MBS item 732);
- Annual Cycles of Care;
- Referral forms for Allied Health services (including referral forms for group Allied Health services, when the 'Minimise diabetes lifestyle risk factors' goal, in the Lifestyle section, is added to the care plan of a patient with diabetes type II. See Chapter 4.2.5.1 Adding, Editing and Deleting Goals and Tasks); and
- Referral forms for Home Medicines Review (HMR) (MBS Item 900) (when the Domiciliary medication management review task is added to the Correct use of medications goal of the Medications section of the Planning page – you will be warned that this document will be generated automatically when

the GPMP is approved. See Chapter 4.2.5.1 Adding, Editing and Deleting Goals and Tasks)

When a document has not yet been approved (such as GPMP or TCA) a Drafts section is displayed, containing the related documents.

The Supporting Documents section contains documents that accompany the care plan, including referral forms for Allied Health services or Home Medicines Review (HMR). Allied Health services documents will only be available when the TCA has been approved (as long as you allocate a number of services for the individual Allied Health providers). When supporting documents are already available for the current year, Primary Care Providers and Care Plan Creators can create new or modify existing supporting documents (where available) to prepare for the following year and future needs of the patient by clicking Create/Modify Supporting Document.

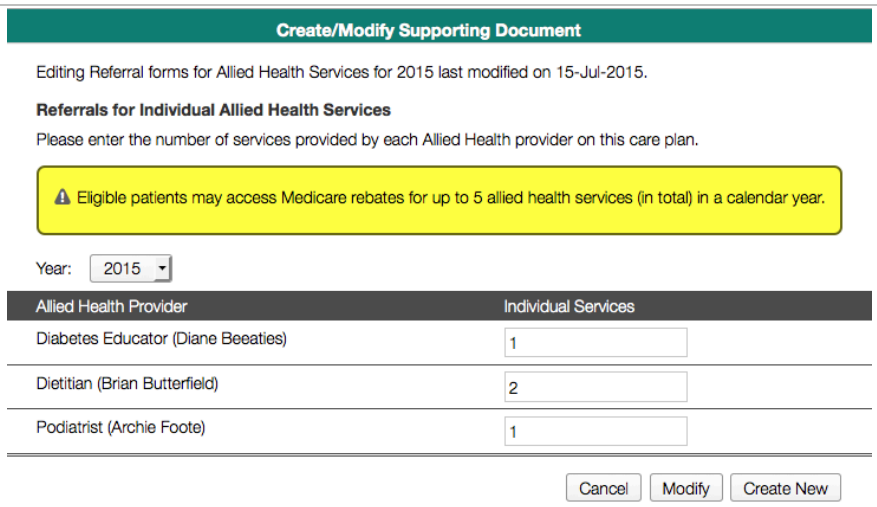


Figure 50. Create or Modify Supporting Documents

If a patient is of Aboriginal or Torres Strait Islander descent, Primary Care Providers and Care Plan Creators can also create new or modify existing supporting documents to include Indigenous Allied Health Services.

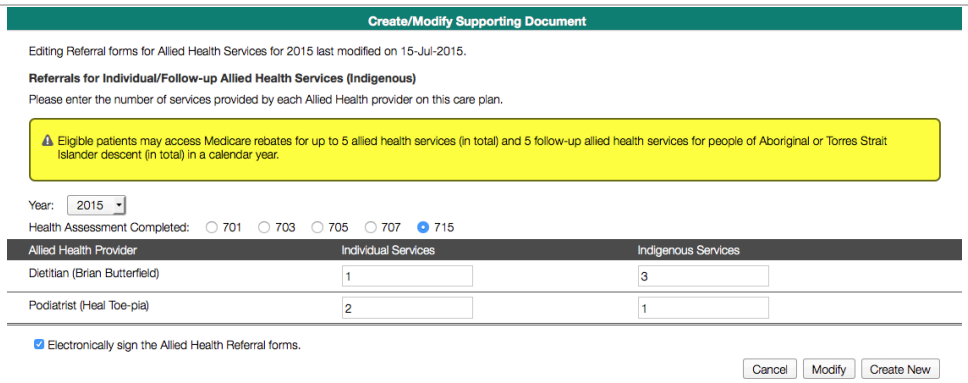


Figure 51. Create or Modify Supporting Documents Including Indigenous Services

4.2.9 Assessments Page

You can create an assessment for a patient at any time provided that you have access to their health record.

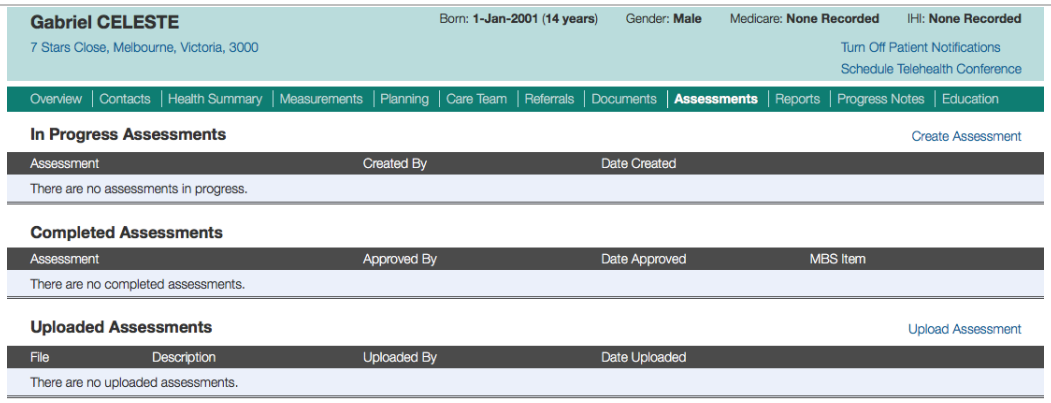


Figure 52. Assessments Page

Click Create Assessment to begin an assessment.

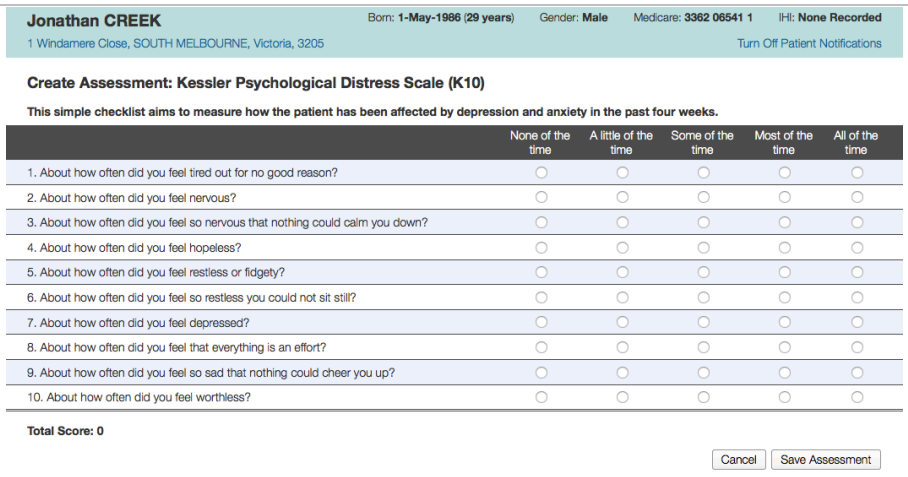


Figure 53. Creating Assessment

Fill in the assessment accordingly, ideally making sure you answer all questions. You can save an incomplete assessment by clicking Save Assessment and come back to it later. When you save the assessment, it goes into the In Progress Assessments section. Click Edit next to the assessment name in the In Progress Assessments section if you want to continue it, change or add to your previous answers. You can view a PDF version of an assessment (whether it is in progress or approved) by clicking the assessment name. Some components of assessments may already be pre-filled with data from the patient's health record, which (depending on the assessment) you can edit at your discretion. When you are happy with the assessment, click Approve

in the Actions column of the In Progress Assessments section. You cannot approve incomplete assessments.

Certain assessments can be associated with specific MBS item numbers. When this applies, cdmNet prompts you to select an appropriate MBS item. Alternatively, you can choose 'Not claiming through Medicare'.

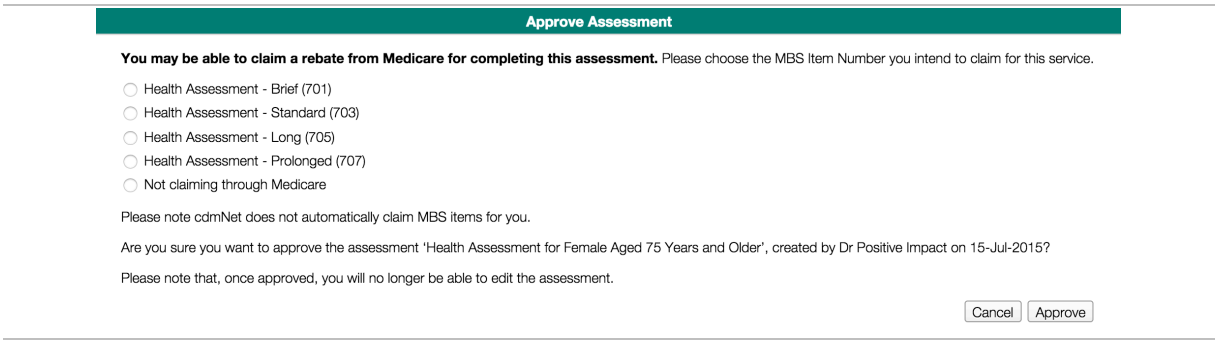


Figure 54. Approving an Assessment with MBS item numbers

After approval, the assessment goes into the Completed Assessments section. cdmNet adds a Progress Notes entry and makes the assessment available for viewing on the Assessments page (for all care team members, as well as the patient). You can also delete assessments by clicking Delete. (Please note that approved assessments with associated MBS items cannot be deleted.)

If you approved an assessment and associated it with an MBS item, you can see the details of this assessment in the Reports section (see Chapter 5 Reports).

To upload an existing assessment you have completed outside cdmNet, click Upload Assessment. Note that all care team members, including the patient, can view or download any assessments you upload.

Just as with the uploaded documents on the Referrals Page, you can control the visibility of uploaded assessments. Simply click the 'Specific people' radio button and edit the list of providers accordingly when uploading the assessment (or later, if required).

4.2.10 Reports Page

At present, reports are only available for patients from some practices, participating in certain programs.

4.2.11 Progress Notes Page

The Progress Notes page is where everyone involved in the patient's care (including the patient themselves) can make notes about the patient's progress. The page also displays information about when major milestones (such as GPMPs, TCAs and reviews) related to the patient's care plan occurred.

You can only delete notes that you have entered. When you delete a note, cdmNet prompts you to enter a reason for deleting the note. Deleted notes are distinguishable by the grey header.

Any notes that you have not seen are marked with a red circle. Basic information about unseen notes is also displayed in the Unseen Notes widget on the Overview page.

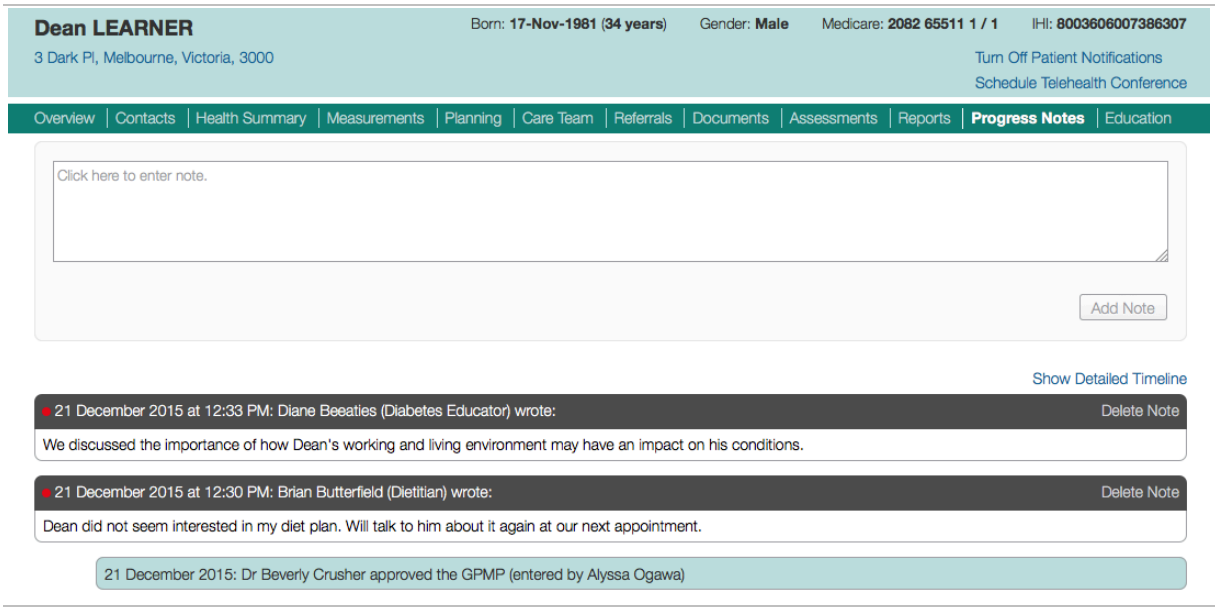


Figure 55. Progress Notes Page

Clicking Show Detailed Timeline displays the full list of notes and notifications, including GPMP approvals, the details of TCA agreements from care team members, and so on.

When someone adds new progress notes (including as a result of uploading a document or scheduling a telehealth conference), the green navigation bar indicates that new notes have been added.

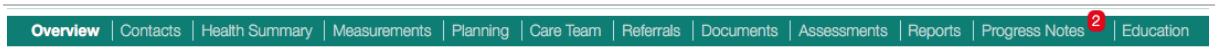


Figure 56. Navigation Bar with Progress Notes Notification

You will also find a notification badge next to the name of the patient on your patient list when new progress notes have been added. On the patient list, select

the filter 'patients with unseen notes' to view only those patients for whom you have not read new Progress Notes.

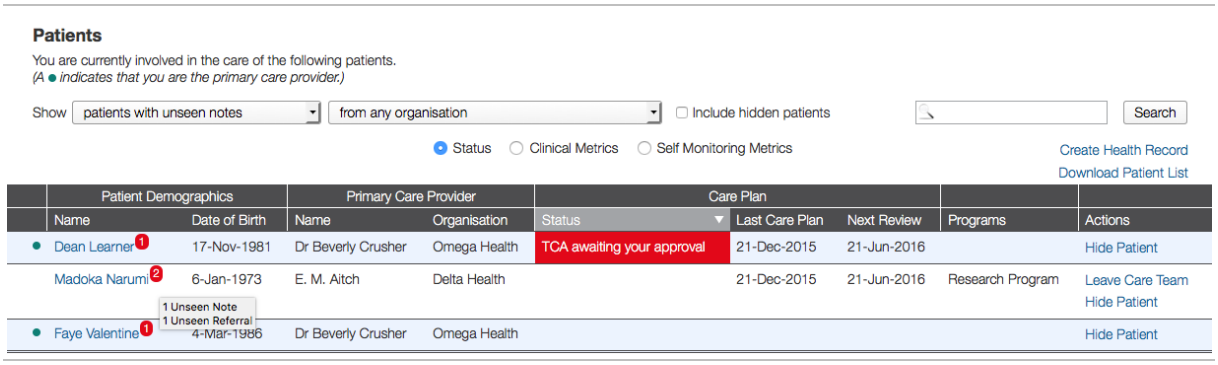


Figure 57. Patient List With Notification of New Progress Notes and Referral

Hover your mouse over the notification badge on the patient list and a 'tooltip' appears to tell you which sorts of unseen items are available (progress notes or referrals).

4.2.12 Education Page

The Education page displays links and information that may be relevant to a patient's health record.

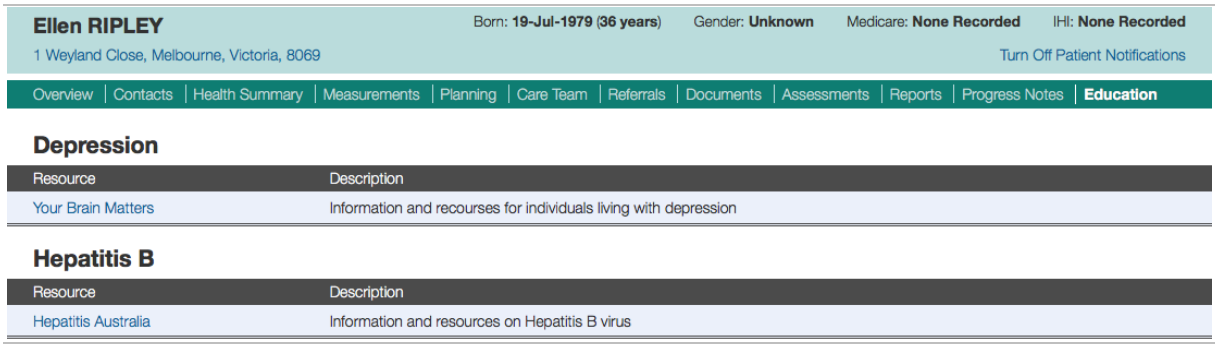


Figure 58. Education Page

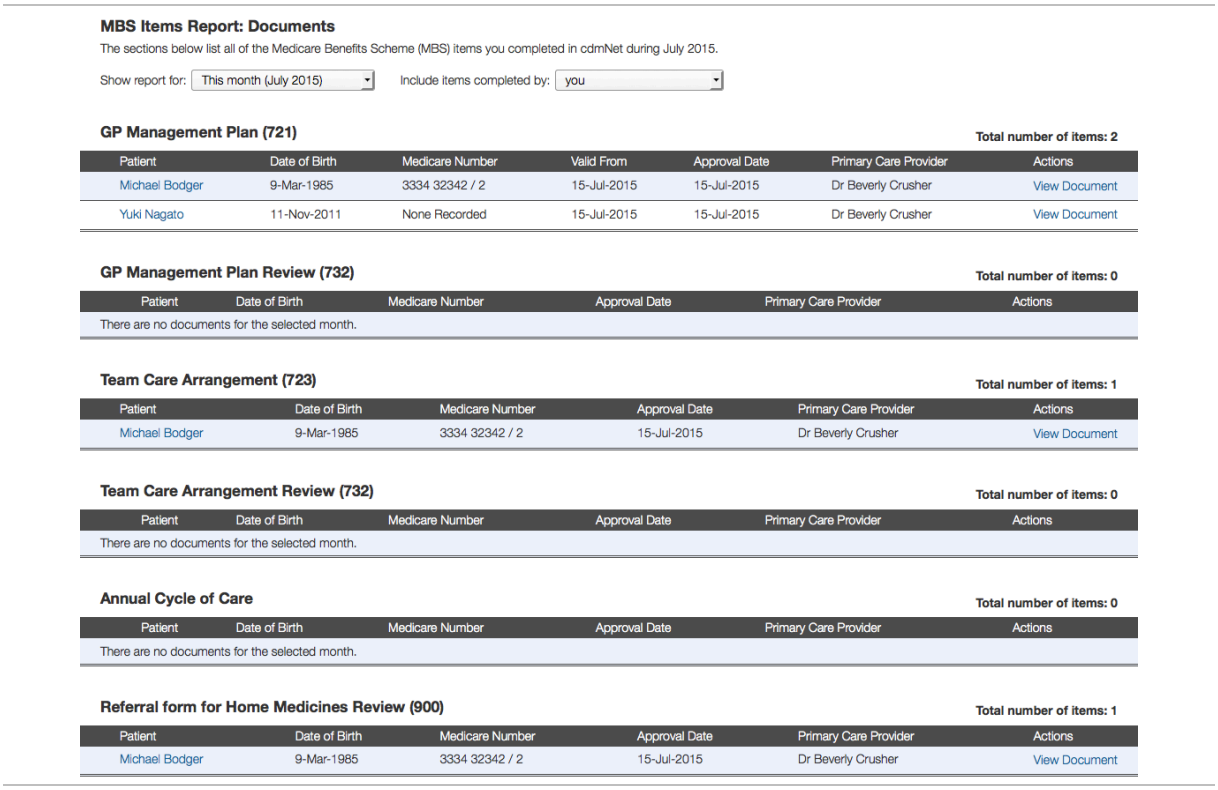
5 Reports

Figure 59. MBS Items Reports

The reports shown in this section vary depending on your speciality, how you have used cdmNet and whether you are participating in any research programs.

If you are a PCP or a CPC, click the MBS Items Report: Documents link to display a page containing six categories of your completed MBS Items:

- GP Management Plan (721);
- GP Management Plan Review (732);
- Team Care Arrangement (723);
- Team Care Arrangement Review (732);
- Annual Cycle of Care; and
- Referral forms for Home Medicines Review (HMR) (900).



MBS Items Report: Documents

The sections below list all of the Medicare Benefits Scheme (MBS) items you completed in cdmNet during July 2015.

Show report for: This month (July 2015) Include items completed by: you

GP Management Plan (721) Total number of items: 2

Patient	Date of Birth	Medicare Number	Valid From	Approval Date	Primary Care Provider	Actions
Michael Bodger	9-Mar-1985	3334 32342 / 2	15-Jul-2015	15-Jul-2015	Dr Beverly Crusher	View Document
Yuki Nagato	11-Nov-2011	None Recorded	15-Jul-2015	15-Jul-2015	Dr Beverly Crusher	View Document

GP Management Plan Review (732) Total number of items: 0

Patient	Date of Birth	Medicare Number	Approval Date	Primary Care Provider	Actions
There are no documents for the selected month.					

Team Care Arrangement (723) Total number of items: 1

Patient	Date of Birth	Medicare Number	Approval Date	Primary Care Provider	Actions
Michael Bodger	9-Mar-1985	3334 32342 / 2	15-Jul-2015	Dr Beverly Crusher	View Document

Team Care Arrangement Review (732) Total number of items: 0

Patient	Date of Birth	Medicare Number	Approval Date	Primary Care Provider	Actions
There are no documents for the selected month.					

Annual Cycle of Care Total number of items: 0

Patient	Date of Birth	Medicare Number	Approval Date	Primary Care Provider	Actions
There are no documents for the selected month.					

Referral form for Home Medicines Review (900) Total number of items: 1

Patient	Date of Birth	Medicare Number	Approval Date	Primary Care Provider	Actions
Michael Bodger	9-Mar-1985	3334 32342 / 2	15-Jul-2015	Dr Beverly Crusher	View Document

Figure 60. Reports Page for Documents

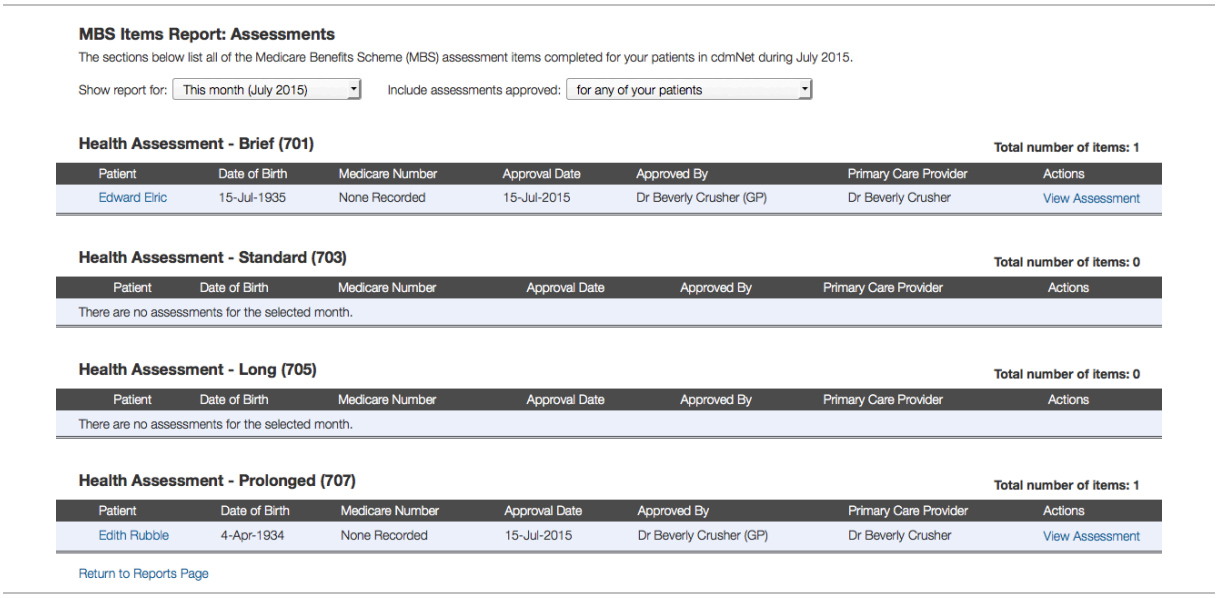
The reports collated on this page relate to the various types of documents generated at particular stages of patients' chronic disease management plan. You can select the documents that pertain to a particular month by selecting a month in the 'Show report for' menu.

If you are a Care Plan Creator, you can select to view the MBS items completed by your Primary Care Provider(s).

Click a patient's name to view their health record.

Click View Document to the right of a patient's name, under the Actions column to view a particular document under the desired section.

Note if you are a PCP you can view all documents that you approved or that were approved on your behalf. If you are a CPC you can see all documents that were approved by or on behalf of your Primary Care Providers.



MBS Items Report: Assessments

The sections below list all of the Medicare Benefits Scheme (MBS) assessment items completed for your patients in cdmNet during July 2015.

Show report for: This month (July 2015) Include assessments approved: for any of your patients

Health Assessment - Brief (701) Total number of items: 1

Patient	Date of Birth	Medicare Number	Approval Date	Approved By	Primary Care Provider	Actions
Edward Elric	15-Jul-1935	None Recorded	15-Jul-2015	Dr Beverly Crusher (GP)	Dr Beverly Crusher	View Assessment

Health Assessment - Standard (703) Total number of items: 0

Patient	Date of Birth	Medicare Number	Approval Date	Approved By	Primary Care Provider	Actions
There are no assessments for the selected month.						

Health Assessment - Long (705) Total number of items: 0

Patient	Date of Birth	Medicare Number	Approval Date	Approved By	Primary Care Provider	Actions
There are no assessments for the selected month.						

Health Assessment - Prolonged (707) Total number of items: 1

Patient	Date of Birth	Medicare Number	Approval Date	Approved By	Primary Care Provider	Actions
Edith Rubble	4-Apr-1934	None Recorded	15-Jul-2015	Dr Beverly Crusher (GP)	Dr Beverly Crusher	View Assessment

Return to Reports Page

Figure 61. Reports Page for Assessments

All providers can click the MBS Items Report: Assessments link.

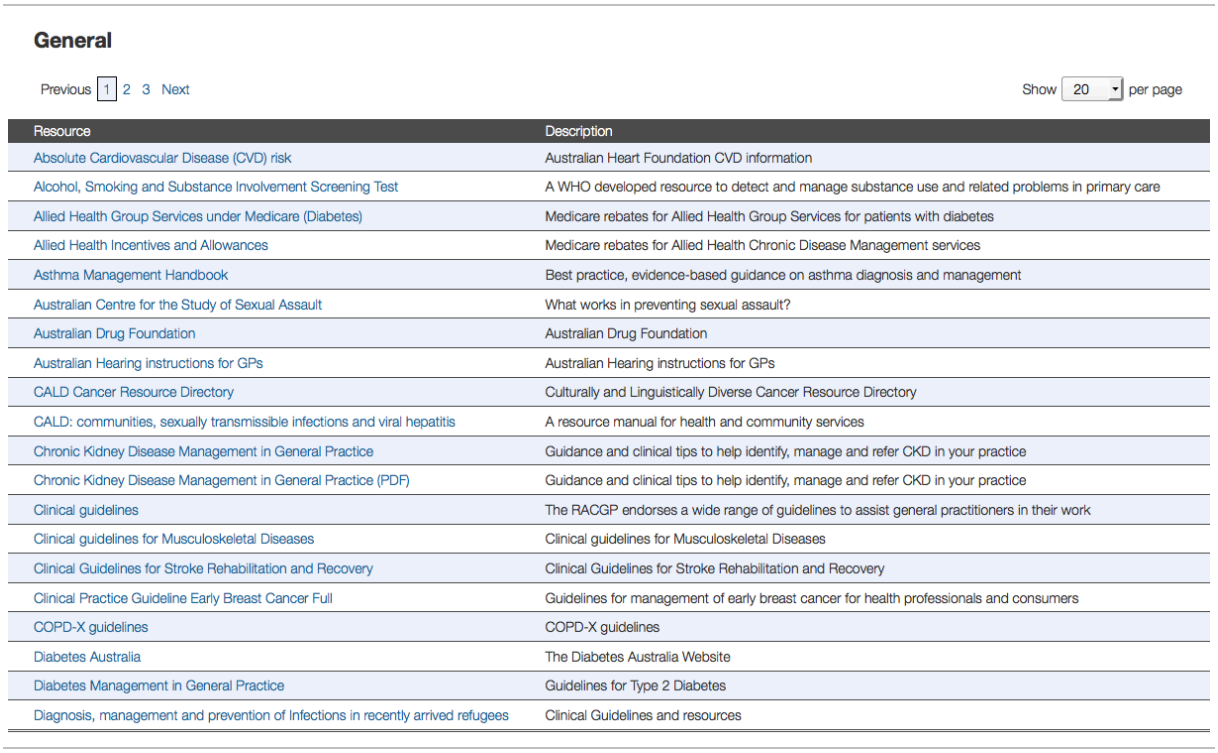
The reports collated on this page relate to the various MBS items generated upon approval of assessments with associated MBS item. You can see the assessments that pertain to a particular month by selecting a month in the 'Show report for' menu.

If you are a Primary Care Provider, you can select to view assessments with associated MBS items approved by you or for any of your patients. (Note that some assessments can be created and approved with an associated MBS item by a provider on your patient's care team or even by the patient.)

If you are a Care Plan Creator, you can select to view the approved assessments with associated MBS items completed by your Primary Care Provider(s).

6 Resources

All providers have the following standard list of Resources.



General

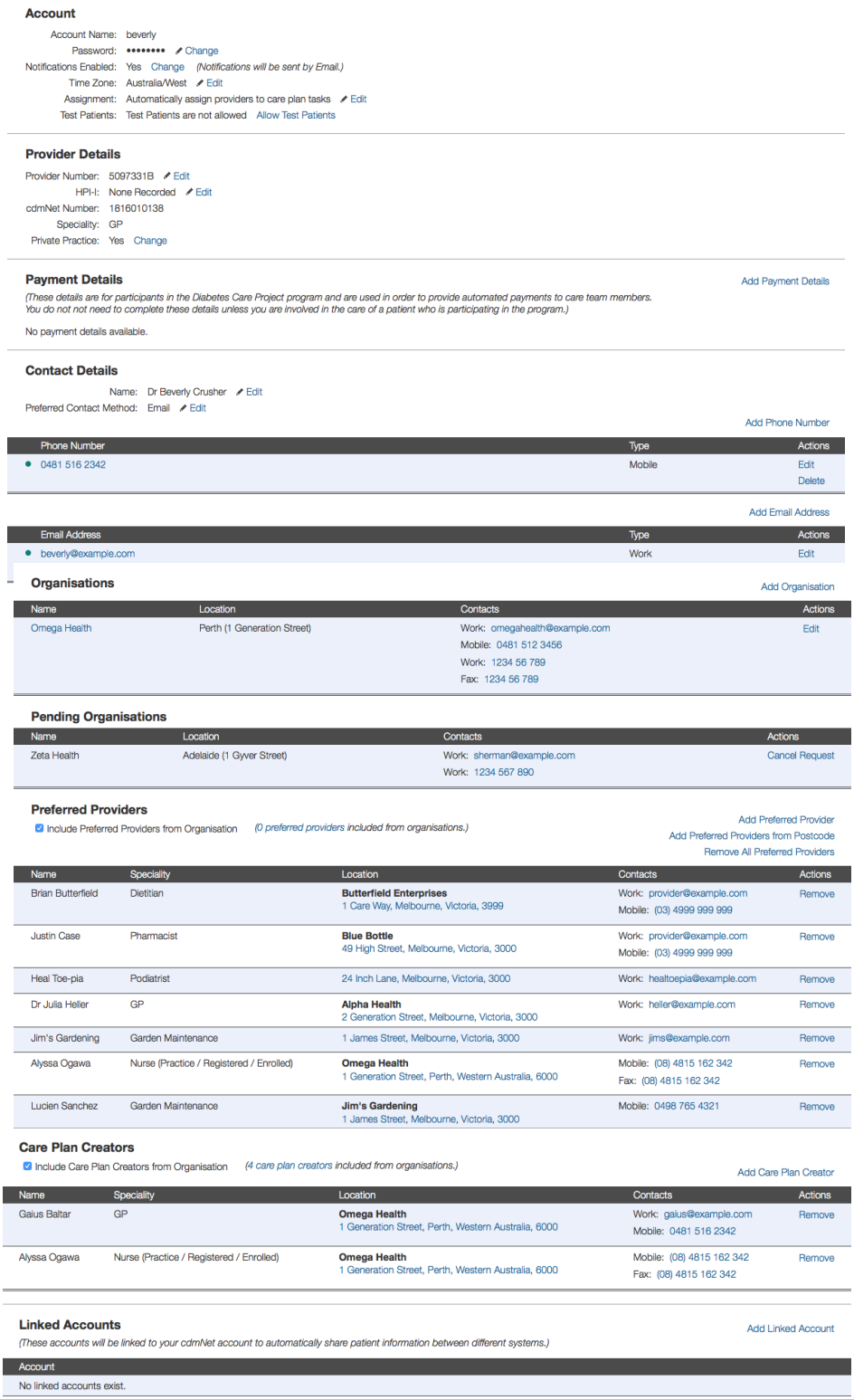
Previous 1 2 3 Next Show 20 per page

Resource	Description
Absolute Cardiovascular Disease (CVD) risk	Australian Heart Foundation CVD information
Alcohol, Smoking and Substance Involvement Screening Test	A WHO developed resource to detect and manage substance use and related problems in primary care
Allied Health Group Services under Medicare (Diabetes)	Medicare rebates for Allied Health Group Services for patients with diabetes
Allied Health Incentives and Allowances	Medicare rebates for Allied Health Chronic Disease Management services
Asthma Management Handbook	Best practice, evidence-based guidance on asthma diagnosis and management
Australian Centre for the Study of Sexual Assault	What works in preventing sexual assault?
Australian Drug Foundation	Australian Drug Foundation
Australian Hearing instructions for GPs	Australian Hearing instructions for GPs
CALD Cancer Resource Directory	Culturally and Linguistically Diverse Cancer Resource Directory
CALD: communities, sexually transmissible infections and viral hepatitis	A resource manual for health and community services
Chronic Kidney Disease Management in General Practice	Guidance and clinical tips to help identify, manage and refer CKD in your practice
Chronic Kidney Disease Management in General Practice (PDF)	Guidance and clinical tips to help identify, manage and refer CKD in your practice
Clinical guidelines	The RACGP endorses a wide range of guidelines to assist general practitioners in their work
Clinical guidelines for Musculoskeletal Diseases	Clinical guidelines for Musculoskeletal Diseases
Clinical Guidelines for Stroke Rehabilitation and Recovery	Clinical Guidelines for Stroke Rehabilitation and Recovery
Clinical Practice Guideline Early Breast Cancer Full	Guidelines for management of early breast cancer for health professionals and consumers
COPD-X guidelines	COPD-X guidelines
Diabetes Australia	The Diabetes Australia Website
Diabetes Management in General Practice	Guidelines for Type 2 Diabetes
Diagnosis, management and prevention of Infections in recently arrived refugees	Clinical Guidelines and resources

Figure 62. Resources Page

Clicking any of the links under the Resource column opens a new window with information that corresponds with its Description.

7 Preferences



Account

Account Name: beverly
Password: •••••••• Change
Notifications Enabled: Yes Change *(Notifications will be sent by Email.)*
Time Zone: Australia/West Edit
Assignment: Automatically assign providers to care plan tasks Edit
Test Patients: Test Patients are not allowed Allow Test Patients

Provider Details

Provider Number: 5097331B Edit
HPI-I: None Recorded Edit
cdmNet Number: 1816010138
Speciality: GP
Private Practice: Yes Change

Payment Details Add Payment Details

(These details are for participants in the Diabetes Care Project program and are used in order to provide automated payments to care team members. You do not not need to complete these details unless you are involved in the care of a patient who is participating in the program.)

No payment details available.

Contact Details

Name: Dr Beverly Crusher Edit
Preferred Contact Method: Email Edit

Add Phone Number

Phone Number	Type	Actions
0481 516 2342	Mobile	Edit Delete

Add Email Address

Email Address	Type	Actions
beverly@example.com	Work	Edit

Organisations Add Organisation

Name	Location	Contacts	Actions
Omega Health	Perth (1 Generation Street)	Work: omegahealth@example.com Mobile: 0481 512 3456 Work: 1234 56 789 Fax: 1234 56 789	Edit

Pending Organisations

Name	Location	Contacts	Actions
Zeta Health	Adelaide (1 Gyver Street)	Work: sherman@example.com Work: 1234 567 890	Cancel Request

Preferred Providers

Include Preferred Providers from Organisation *(0 preferred providers included from organisations.)*

Add Preferred Provider
Add Preferred Providers from Postcode
Remove All Preferred Providers

Name	Speciality	Location	Contacts	Actions
Brian Butterfield	Dietitian	**Butterfield Enterprises** 1 Care Way, Melbourne, Victoria, 3999	Work: provider@example.com Mobile: (03) 4999 999 999	Remove
Justin Case	Pharmacist	**Blue Bottle** 49 High Street, Melbourne, Victoria, 3000	Work: provider@example.com Mobile: (03) 4999 999 999	Remove
Heal Toe-pia	Podiatrist	24 Inch Lane, Melbourne, Victoria, 3000	Work: healtoepia@example.com	Remove
Dr Julia Heller	GP	**Alpha Health** 2 Generation Street, Melbourne, Victoria, 3000	Work: heller@example.com	Remove
Jim's Gardening	Garden Maintenance	1 James Street, Melbourne, Victoria, 3000	Work: jims@example.com	Remove
Alyssa Ogawa	Nurse (Practice / Registered / Enrolled)	**Omega Health** 1 Generation Street, Perth, Western Australia, 6000	Mobile: (08) 4815 162 342 Fax: (08) 4815 162 342	Remove
Lucien Sanchez	Garden Maintenance	**Jim's Gardening** 1 James Street, Melbourne, Victoria, 3000	Mobile: 0498 765 4321	Remove

Care Plan Creators

Include Care Plan Creators from Organisation *(4 care plan creators included from organisations.)*

Add Care Plan Creator

Name	Speciality	Location	Contacts	Actions
Gaius Baltar	GP	**Omega Health** 1 Generation Street, Perth, Western Australia, 6000	Work: gaius@example.com Mobile: 0481 516 2342	Remove
Alyssa Ogawa	Nurse (Practice / Registered / Enrolled)	**Omega Health** 1 Generation Street, Perth, Western Australia, 6000	Mobile: (08) 4815 162 342 Fax: (08) 4815 162 342	Remove

Linked Accounts Add Linked Account

(These accounts will be linked to your cdmNet account to automatically share patient information between different systems.)

Account
No linked accounts exist.

Figure 63. Preferences Page

The Preferences shows eight sections:

- Your Account Details;

- Your Provider Details;
- Your Payment Details;
- Your Contact Details;
- The Organisations to which you belong;
- Pending Organisations (this appears when you have requested to join an organisation but not yet been accepted);
- Your Preferred Providers; (for PCPs only)
- Your Care Plan Creators; (for PCPs and Health Record Creators only) and
- Your Linked Accounts (for PCPs only).

7.1 Account Details

Your Account Details relate to you as a user of cdmNet. You can:

- Change your password;
- Enable or disable notifications from cdmNet;
- Change your Time Zone (Time Zones within Australia only);
- Edit the Automatic Assignment of providers to care plans; and
- Allow or not allow Test Patients (see Chapter 4.1.1 Test Patients)

7.2 Provider Details

Your Provider Details relate to you as a provider. Clicking Edit Provider Details enables you to:

- Change your Provider Number;
- Change your HPI-I; and
- Change whether you (as a provider) work privately.

7.3 Payment Details

These details are used to provide automated payments to care team members participating in the Diabetes Care Project program. You need only fill in your details if you are participating in this program.

7.4 Contact Details

Your Contact Details relate to your methods of contact. You can:

- Edit or change your Name;
- Edit or change your Preferred Method of Contact;
- Add, edit or delete Phone Numbers;

- Add, edit, or delete addresses; and
- Add, edit or delete Email addresses.

A contact detail with a green dot next to it means that it is the primary instance of that type of contact detail.

Please note that cdmNet only sends some notifications by fax. If you select fax as your preferred method of contact, other notifications will be sent by email or SMS if you have these details recorded.

7.5 Organisations

The list of organisations shows those you belong to as a provider. You can register a new organisation (to which you will automatically belong once you have completed the registration process) by clicking Register a New Organisation and filling in the appropriate details in the boxes provided.

You can view the details of an organisation in your list by clicking its name or clicking Edit. The Preferences page of an organisation is very similar to your own Preferences page.

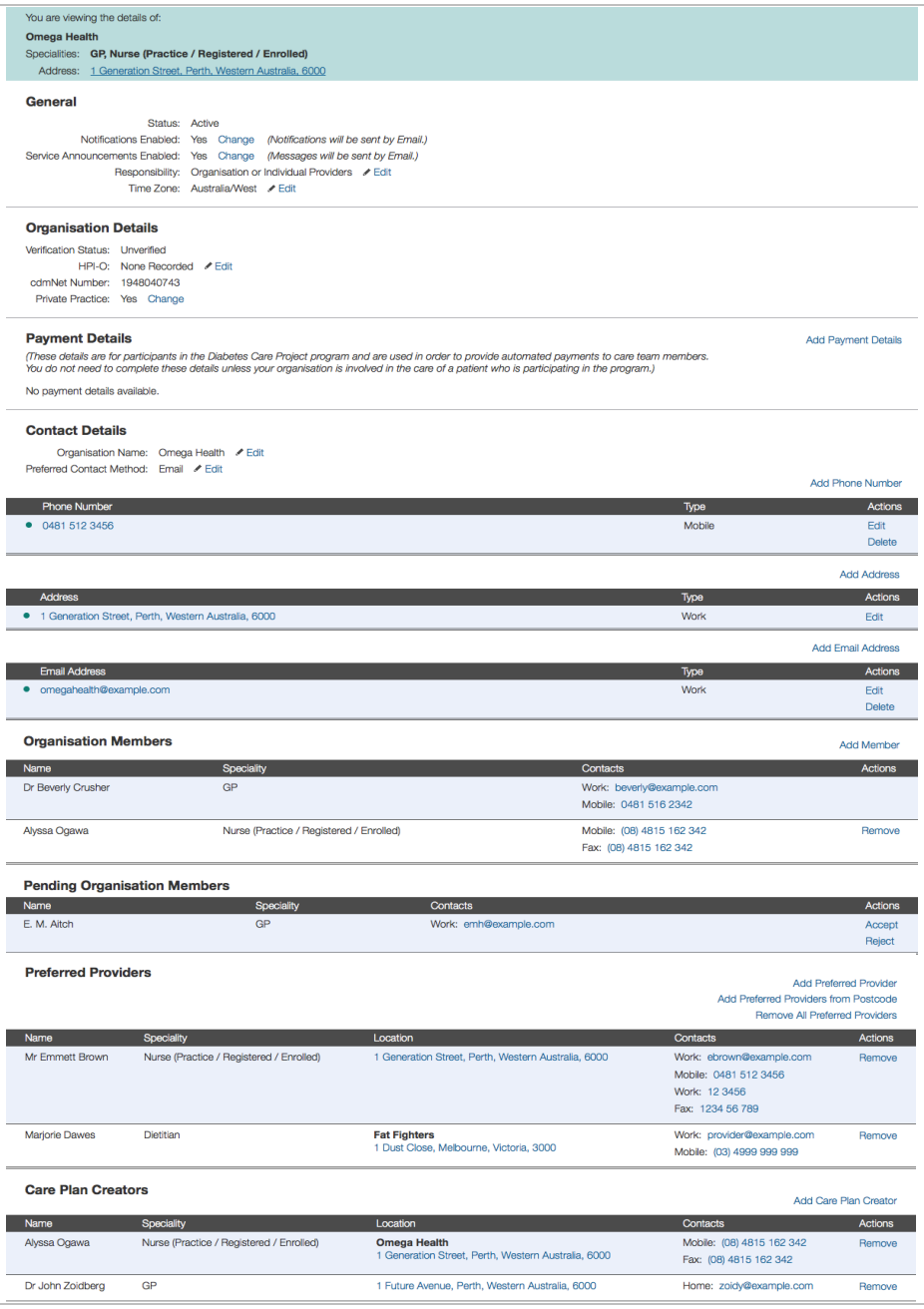


Figure 64. Organisation Preferences Page

From an organisation's preferences page, you can:

- Edit the General details (including whether tasks are assigned; only to the organisation; individual providers within the organisation; or to the organisation or to individual providers within the organisation);
- Edit the Organisation Details (including whether the organisation is a private practice);
- Edit the Payment Details (you need only fill these in if the organisation is involved in the care of a patient who is participating in the Diabetes Care Project);

- Edit the Contact Details;
- Add members to the organisation (see Chapter 7.5.1 Adding Members);
- Remove members from the organisation;
- Accept or reject pending organisation members (see Chapter 7.5.1 Adding Members);
- View the Practice Principals of the organisation (this is only relevant for providers participating in the Diabetes Care Project, if the information shown is incorrect, you should contact Support);
- View addresses of members on a Google Map (by clicking the address);
- Add Preferred Providers to an organisation (Preferred Providers are only available in organisations containing a Primary Care Provider);
- Remove Preferred Providers (where applicable);
- Add Care Plan Creators to an organisation; and
- Remove Care Plan Creators.

7.5.1 Adding Members to an Organisation

To add a member to an organisation, click Add Member to the right of the Organisation Members section heading.

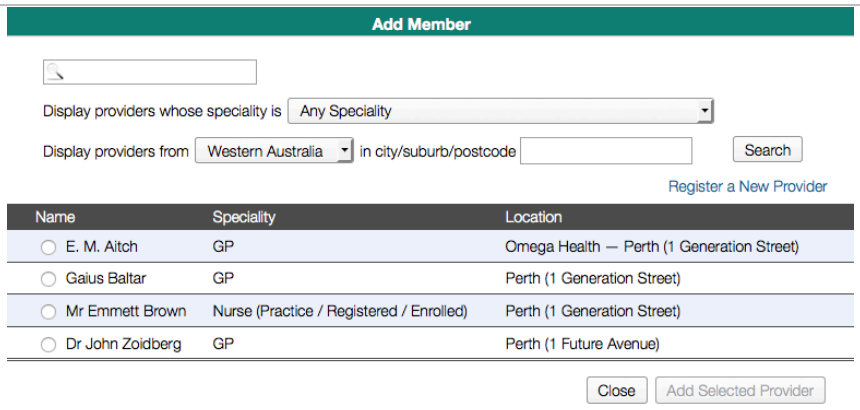


Figure 65. Adding a Member to an Organisation

You can enter a first name, last name or provider number. If you cannot find a provider, they may not be registered with cdmNet. However, you can register a new provider on their behalf by clicking Register a New Provider and filling in the appropriate details in the boxes provided. Providers without these details will not be able to participate in the patient's care using cdmNet. As long as you are able to provide a correct method of contact, that provider should receive a notification with a username and temporary password they can use to log into cdmNet in future.

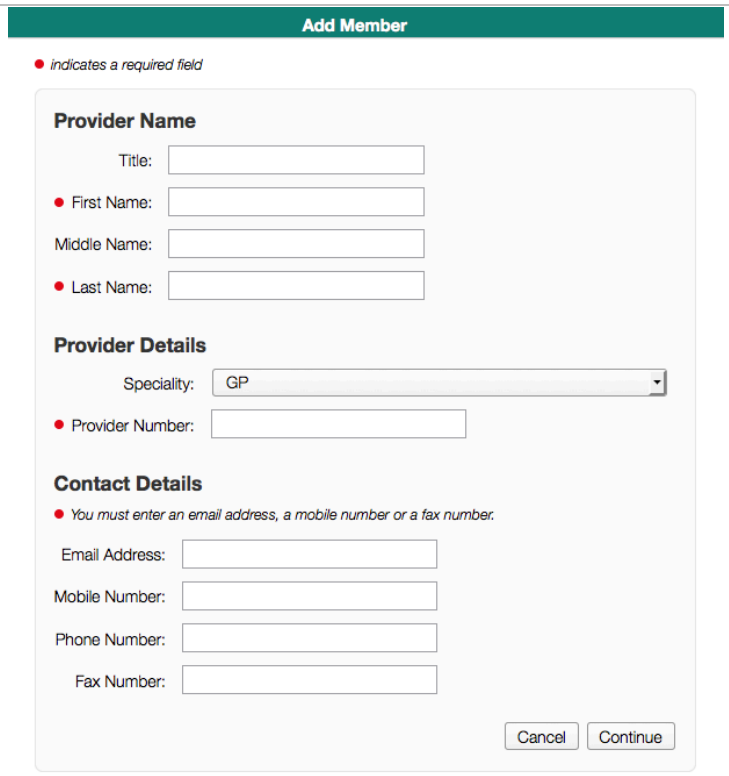


Figure 66. Registering a New Provider

During the process of registration, other providers may indicate that they belong to an organisation to which you already belong. cdmNet records them as pending organisation members. The Pending Organisation Members section appears when there are providers who have requested membership of the organisation, but not yet been accepted. Click Accept or Reject next to the provider's name at your discretion.

7.6 Preferred Providers

Preferred Providers are the providers that you can assign particular tasks to on patient care plans. It is good to add preferred providers to your organisation(s) because that preferred provider list acts as a master list and the providers on that list become available as preferred providers to the other GPs within the organisation(s).

To add a preferred provider to an organisation, click Add Preferred Provider to the right of the Preferred Providers section heading.

You can add preferred providers by clicking:

- Add Preferred Provider; and
- Add Preferred Providers from Postcode.

Clicking Add Preferred Provider displays a page similar to Figure 65 (including the option of registering a new provider on their behalf).

To search for providers by postcode, simply enter the postcode from which you would like to add preferred providers. cdmNet then automatically adds all registered providers from that postcode (both individuals and organisations).

Once there are preferred providers in the organisation's Preferred Providers list, on your own Preferences page, next to the Preferred Providers heading is a tick box labelled 'Include Preferred Providers from Organisation'. By default, this tick box is ticked and it means that all of the preferred providers from your organisation(s) are also your preferred providers.

You can also add individual preferred providers to your own Preferred Provider list manually by clicking one of the Add Preferred Providers actions and following the prompts.

7.7 Care Plan Creators

Care Plan Creators are providers whom you permit to create or modify care plans for your patients. You can select a provider from any speciality to be a care plan creator as long as they are already registered in cdmNet. Usually, care plan creators would be other members of your practice or organisation (such as Practice Nurses).

Note that if you are a Health Record Creator, your care plan creators can only access and modify the records of patients for whom you are already selected as the Health Record Creator (your care plan creators cannot create new patient records).

It is often useful to add care plan creators to your organisation's preferences, rather than your own preferences, because the organisation's care plan creator list acts as a master list and the providers on that list automatically become care plan creators for other members of the organisation, by default.

To add a care plan creator to your organisation, click Add Care Plan Creator. Enter your search criteria when cdmNet displays the following.

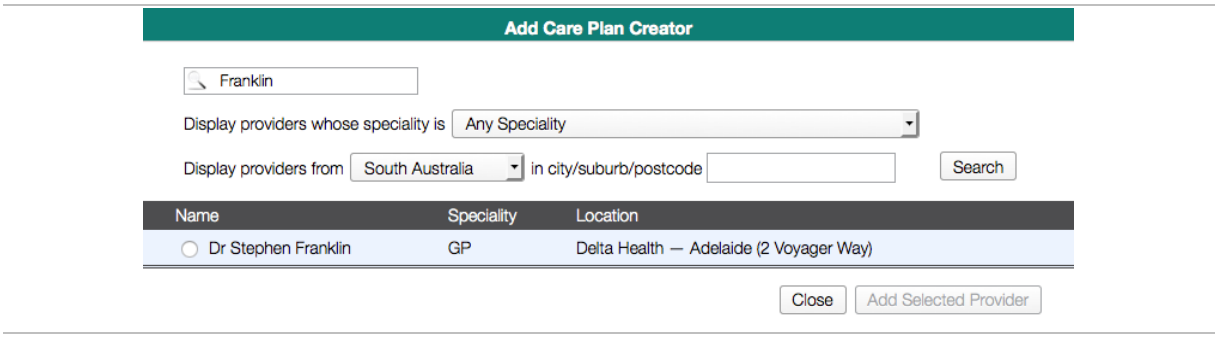


Figure 67. Add Care Plan Creator

Once there are care plan creators in the organisation's Care Plan Creators list, on your own Preferences page, next to the Care Plan Creators heading is a tick box labelled 'Include Care Plan Creators from Organisation'. By default, this tick box is ticked and it means that all of the care plan creators from your organisation(s) are also your care plan creators.

You can also add individual care plan creators to your own Care Plan Creators list manually by clicking the Add Care Plan Creator action and following the prompts.

7.8 Linked Accounts

This is only available to PCPs.

If you have an account in a third-party system that offers integration with cdmNet (for example, Extensia), you can enter the username and password in the Linked Accounts section of your preferences so that cdmNet can communicate with the external system on your behalf.

8 Help

Clicking Help opens a new window with the following page.

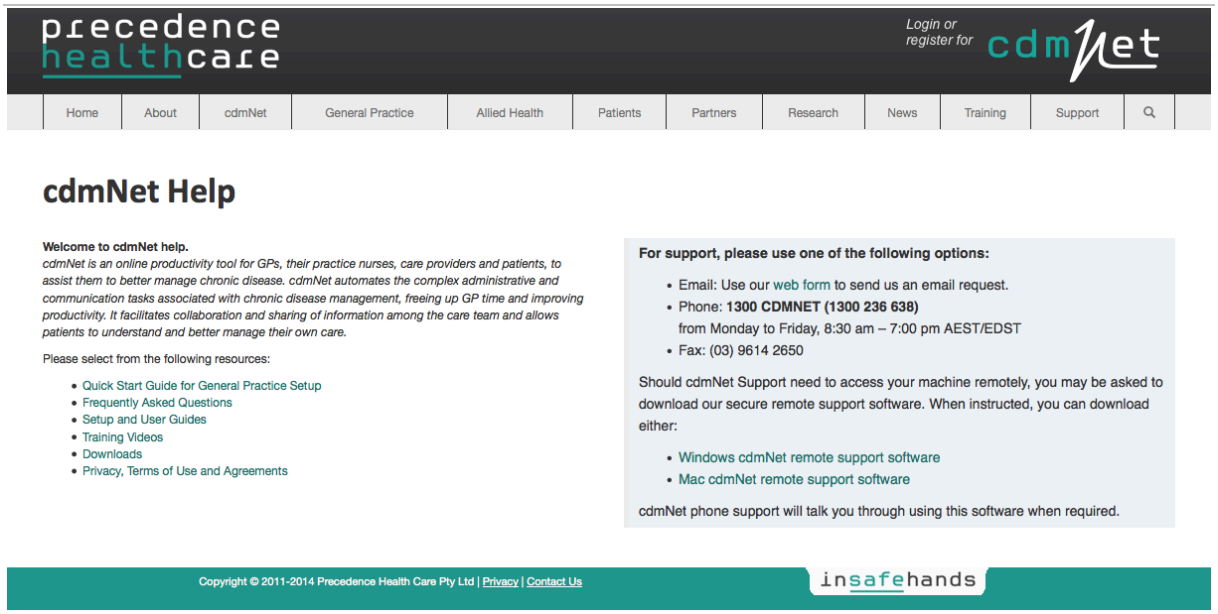


Figure 68. Help Page

On this page you can:

- View other manuals/guides;
- View the Frequently Asked Questions;
- View Training videos;
- Download cdmNet Desktop Software and Installation Guides; and
- View the Privacy, Terms of Use and Agreements pages.

9 Creating Care Plans

As a Primary Care Provider or a Care Plan Creator, you can create care plans for patients.

Creating a care plan for a patient is a two-step process. You have to:

- Create the patient's health record; then
- Create a care plan that is appropriate for the patient.

For information about creating a health record for a patient, see Chapter 4.1 Creating a Patient's Health Record.

9.1 Creating a GP Management Plan

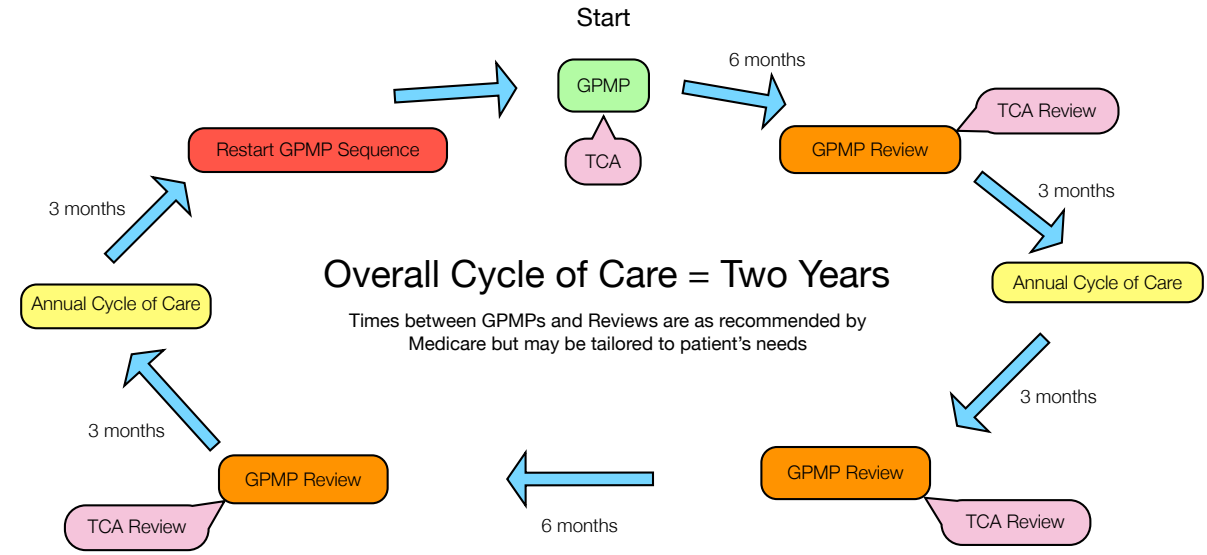


Figure 69. The Cycle of a GPMP

As recommended by Medicare, the duration of the overall cycle of care when implementing GPMPs is two years, as illustrated in Figure 69. Of course, times between GPMPs and Reviews can be tailored to an individual patient's needs.

Once a patient has a health record, you can create a GP Management Plan.

To create a Care Plan, click 'Create Care Plan or Referral' from either the Overview or Planning page when viewing a patient's health record. cdmNet displays the following.

Please note that if you are a Primary Care Provider and nominated as a Care Plan Creator for the patient's Primary Care Provider, as well as being a member of the same organisation, you automatically become the patient's Primary Care Provider if you create their care plan.

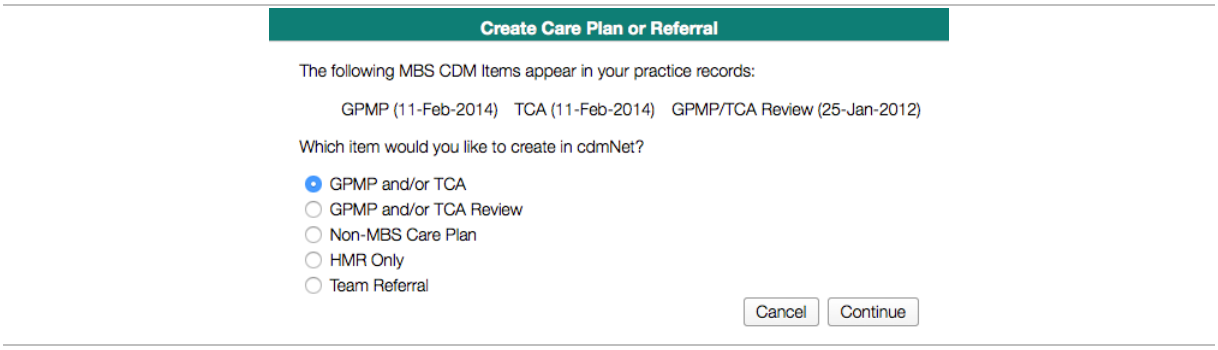


Figure 70. Create Care Plan: Item Selection

If a patient has an existing care plan on paper or in another system, you can start the patient's care plan at the GPMP Review phase in cdmNet.

You can also select to create a non-MBS care plan. This means that you do not create any MBS items (aside from HMR forms) as part of the care plan process.

You can select HMR Only to create a very basic care plan for generating a Home Medicines Review referral. Once you create the care plan, you should assign a pharmacist to the 'Domiciliary medication management review' task and approve the care plan in order to create the Referral form for Home Medicines Review.

You can select Team Referral in order to establish a referral connection with one or more providers and share the patient's health record and progress notes.

When creating a care plan, choose the appropriate option (GPMP and/or TCA, GPMP and/or TCA Review, Non-MBS Care Plan, HMR Only or Team Referral) on the first screen. If cdmNet Desktop has detected previous MBS CDM items in your clinical desktop software (such as GPMPs, TCAs, GPMP Reviews and TCA Reviews), cdmNet displays their details on this screen and pre-selects the review option.

When you click Continue, cdmNet displays the following.

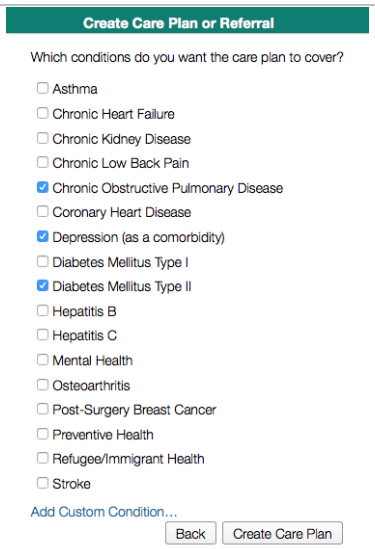


Figure 71. Create Care Plan: Condition Selection

(If you selected HMR Only or Team Referral in the previous step, cdmNet does not prompt you to select conditions.)

Some conditions are initially ticked if they are matched against the Current History section of the Health Summary. You can tick or untick any conditions you want to include or exclude from the care plan. You can also add a custom condition to the care plan by clicking Add Custom Condition… and selecting or entering the condition accordingly. Note that if you add a custom condition, cdmNet will not generate any goals or tasks specific to that condition automatically, so you may need to add custom goals and tasks on the Planning page if you see fit (see Chapter 4.2.5.1 Adding, Editing and Deleting Goals and Tasks).

Once you have selected the conditions you want the care plan to cover, cdmNet generates a proposed care plan for you, based on the patient's information. If you chose the GPMP/TCA option, a newly-created care plan looks like this.

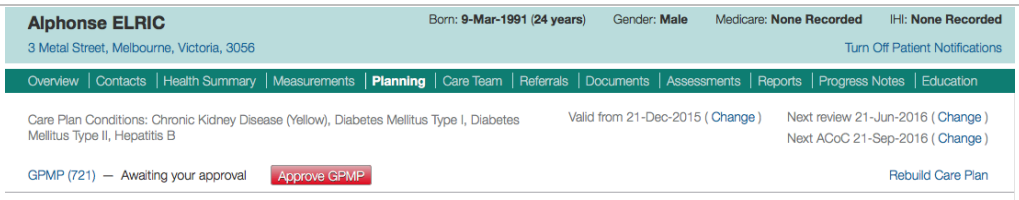


Figure 72. Care Plan Ready For Modification

If you chose the GPMP/TCA Review option, a newly created care plan looks like this.

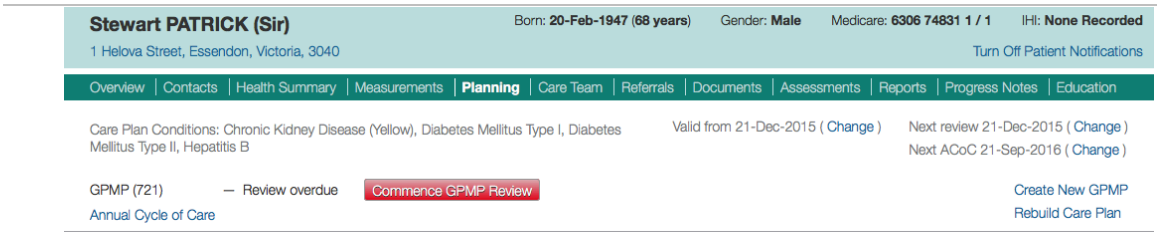


Figure 73. Pre-existing Care Plan Ready For Modification

If you chose this Review option, once you have modified the care plan as desired (see Chapter 9.2 Modifying Care Plans) you should click Commence GPMP Review (see Chapter 9.6 Reviewing GPMPs). Note that care team members, and the patient, will only be able to access the care plan once you approve the GPMP Review.

If you chose the Non-MBS Care Plan option, a newly created care plan looks like this.

Figure 74. Non-MBS Care Plan Ready For Modification

If you made a mistake in creating the care plan or the patient develops a new chronic disease at any stage of the GP Management Plan lifecycle, you can modify the care plan, and repeat the automatic generation process, by clicking Rebuild Care Plan and making the appropriate changes.

9.2 Modifying Care Plans

The Planning and Care Team Pages become available once you have created a care plan for the patient.

Figure 75. Planning Page – Care Plan Modification

You should review the care plan that cdmNet has generated to ensure that it meets the level of care that you believe is appropriate for the patient. It is up to your discretion to modify the care plan according to the patient's needs (see Chapter 4.2.5.1 Adding, Editing and Deleting Goals and Tasks).

In addition to generating a proposed care plan, cdmNet automatically assigns providers to tasks and adds them to the patient's care team based on your Preferred Providers preferences (see Chapter 7.6 Preferred Providers). You can review the care team members by visiting the Care Team page (see Figure 42). You can remove particular care team members if you see fit to do so, but note that any member that you remove may leave tasks unassigned, so you should return to the Planning page and review the changes after you have done so.

If you created a non-MBS, HMR Only or Team Referral care plan that you would like to convert into a GPMP/GPMP Review, you can do so after the care plan has been approved. Simply click Convert Care Plan to GPMP/GPMP Review at the right. Select the appropriate care plan option you wish to convert to when prompted.

For a Team Referral or HMR Only care plan, you may also want to click Rebuild Care Plan and select one or more medical conditions for the care plan to cover, prior to converting to a GPMP/GPMP Review.

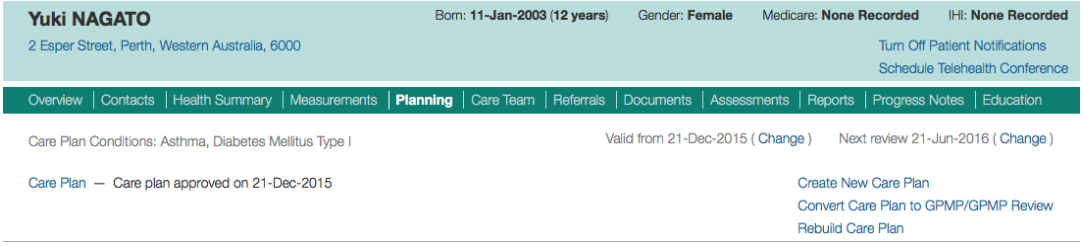


Figure 76. Convert Care Plan to GPMP/GPMP Review

(Please note that converting a non-MBS care plan into a GPMP/GPMP Review is an operation that cannot be undone and you will be charged the fees as explained in the **cdmNet Terms and Conditions.**)

After converting the non-MBS care plan into a GPMP/GPMP Review, the new care plan commences at the approved GPMP or GPMP Review stage (also distributing a TCA to the care team, if you ticked the corresponding box when converting the care plan).

9.3 Approving the GPMP

Once you are happy with the care plan and the care team members associated with it, click Approve GPMP.

If you are a Care Plan Creator preparing the care plan on behalf of the Primary Care Provider, click Release to Primary Care Provider. Upon doing this, cdmNet presents the option of approving the GPMP on behalf of the PCP.

If you are a Primary Care Provider and nominated as a Care Plan Creator for the patient's Primary Care Provider, as well as being a member of the same organisation, clicking Approve GPMP means that you approved the GPMP in your own right, rather than approving on behalf of the patient's usual Primary Care Provider. You can click the Approve GPMP action from the Overview or Planning page.

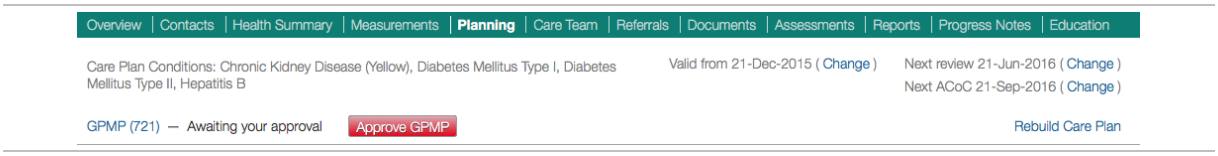


Figure 77. Approve a GPMP

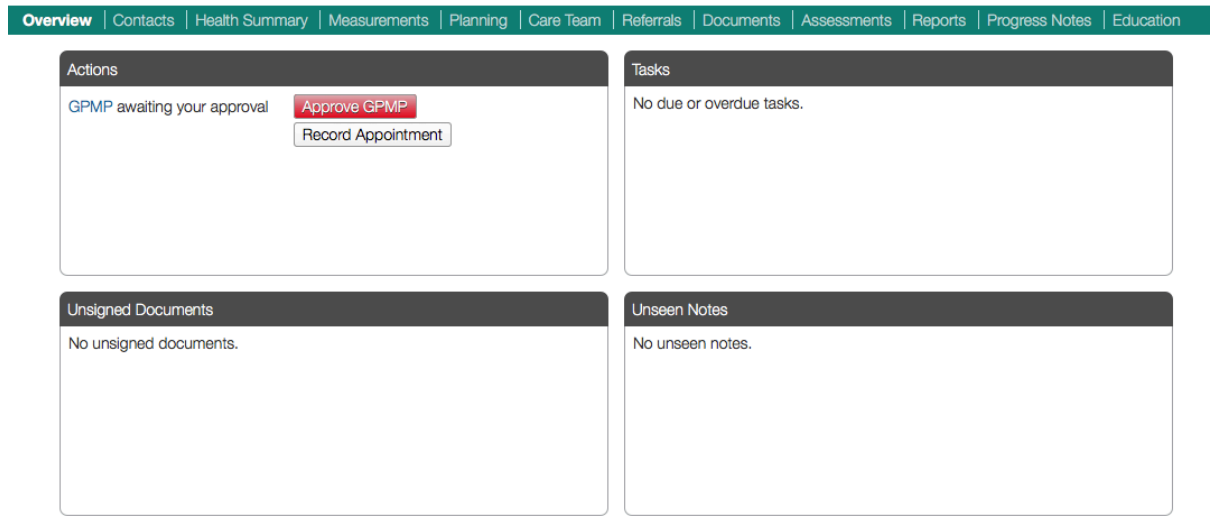


Figure 78. Approve GPMP action on Overview Page

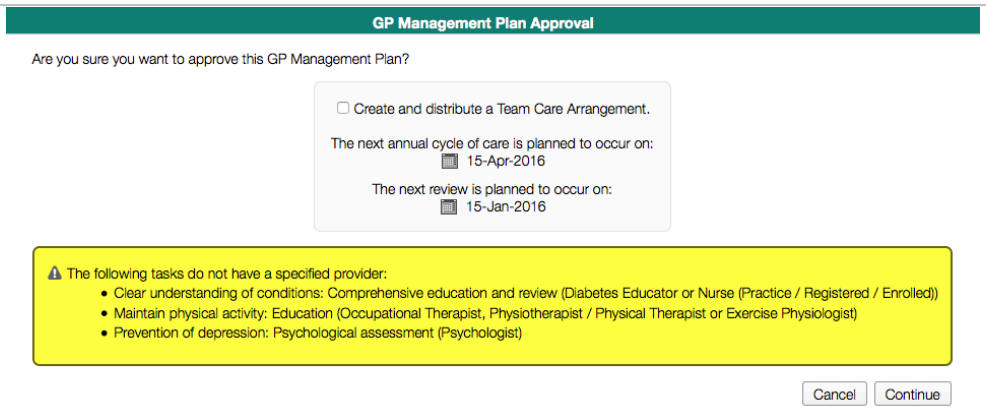


Figure 79. GP Management Plan Approval

Before approving your GPMP, you can set the dates for the next review and annual cycle of care (if the patient has Diabetes§).

You may get a yellow warning box indicating tasks on the care that do not have providers. It is recommended (but not required) that all tasks have assigned providers.

You should ensure that the dates of any GPMPs, TCAs, reviews and ACoCs you conduct using cdmNet are in accordance with Medicare rules for frequency of the relevant MBS items. In some cases, cdmNet warns you if it notices that you have set two of these items to occur closer together than Medicare guidelines suggest, but you are responsible for making the ultimate clinical decision as to what is most appropriate for the care of your patients.

When you approve a care plan (or a review of a care plan), cdmNet gives you the option to notify the care team of the approval.

If you tick 'Create and distribute a Team Care Arrangement', you may be prompted to allocate the number of Allied Health Services for the patient's care plan. The numbers you enter are not final and you can edit them prior to approving the TCA on the Care Team page by clicking Update Services (see Chapter 4.2.6 Care Team Page).

§ While Annual Cycles of Care apply for other conditions, cdmNet only supports Annual Cycles of Care for Diabetes. See Chapter 9.8 Annual Cycles of Care

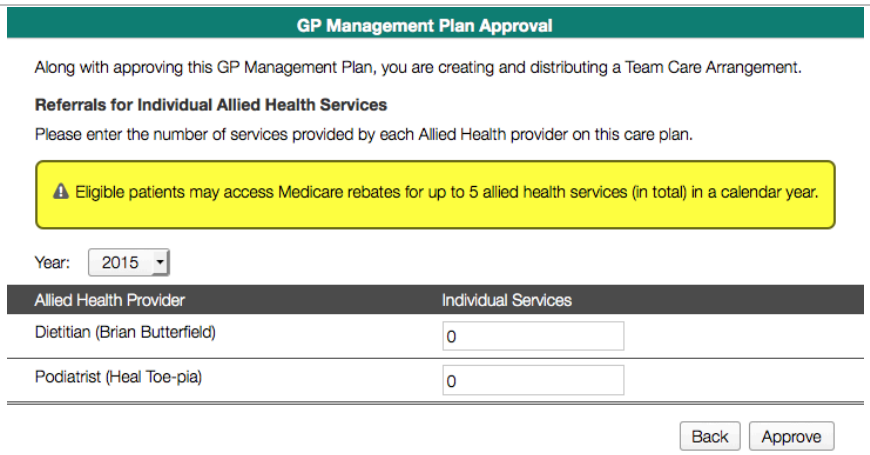


Figure 80. Allocating Allied Health Services While Distributing TCA

9.3.1 What Happens Next

If you ticked 'Create and distribute a Team Care Arrangement' (or subsequently click Create and Distribute TCA), cdmNet notifies the care team members that you have proposed a TCA for the patient.

If you are the Primary Care Provider or a Care Plan Creator, the patient then appears as below on your patient list. On your patient list, you could select the filter 'patients awaiting action from others' to view patients whose health record requires action from members of the care team.

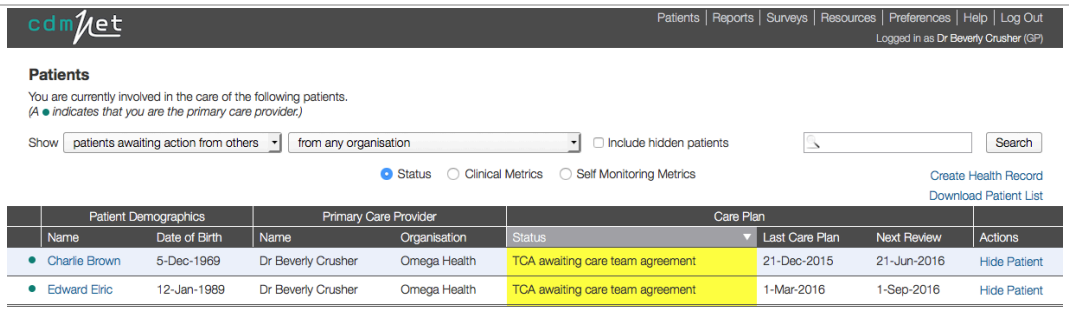


Figure 81. Primary Care Provider -- TCA Awaiting Care Team Agreement

To care team members, the same patient appears as below on the patient list. For care team members, selecting the filter 'patients awaiting action from you' displays patients whose care plans require your action.

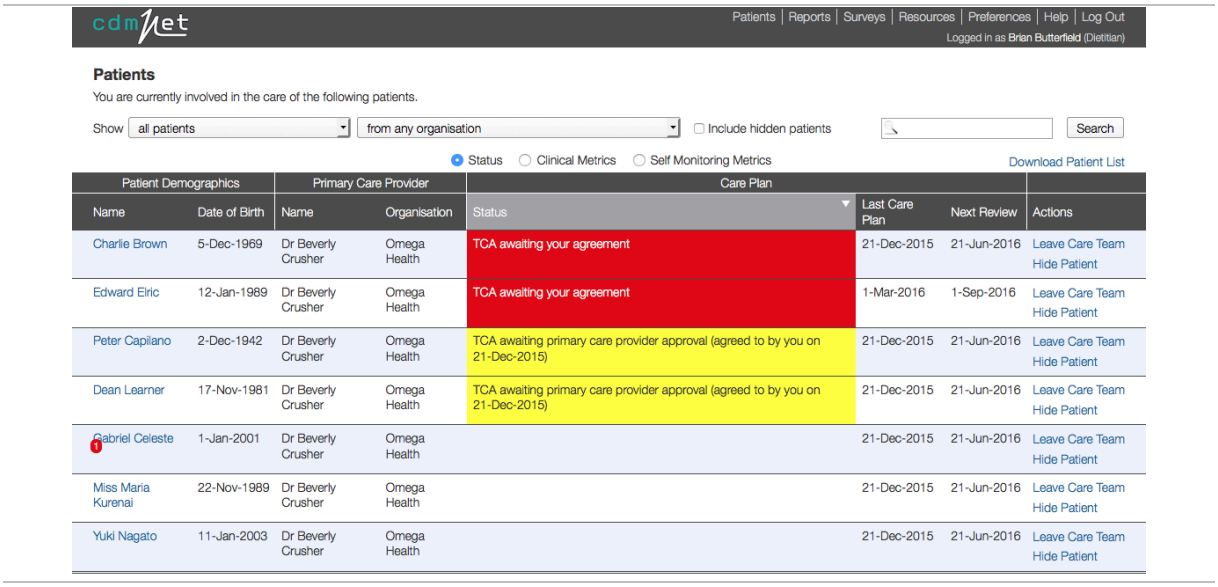


Figure 82. Care Team Member View

If you did not tick the TCA box, cdmNet still notifies your care team that a GPMP exists and prompts them to log in and review it. You can create and distribute a Team Care Arrangement at any later time by clicking Create and Distribute TCA when you see fit.

Once you have approved a GP Management Plan, you can view and download a PDF file corresponding to MBS Item 721 from the Documents page.

You can also view and download the current Care Plan and Patient Summary.

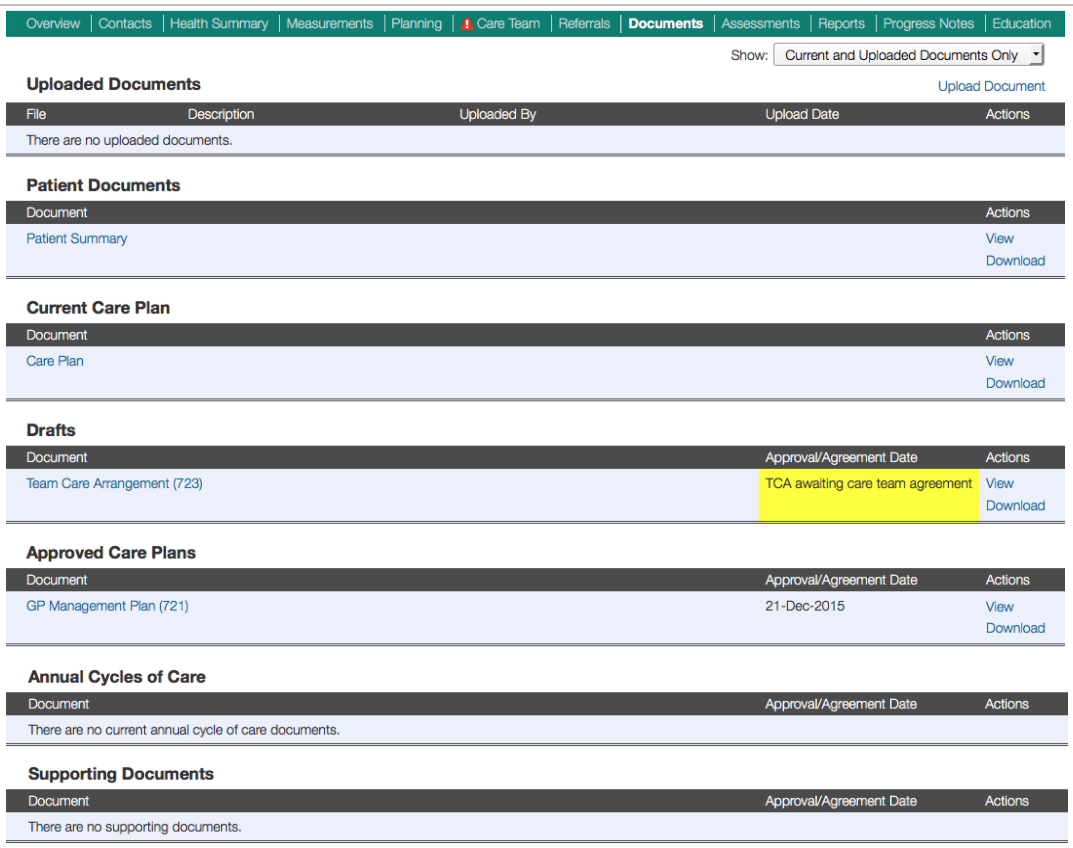


Figure 83. Documents Page with Item 721 Available

If at any time you feel that it is necessary to start a new GPMP for the patient, you can click Create New GPMP.

(Please note that if you are a Primary Care Provider and nominated as a Care Plan Creator for the patient's Primary Care Provider, as well as being a member of the same organisation, clicking Create New GPMP automatically makes you the patient's Primary Care Provider.)

The previous care plan is superseded and a new care plan can be implemented. The 'Valid from' date changes to the current date and the next review and ACoC dates change accordingly.

9.4 Scheduling Telehealth Conferences

A care team member can schedule a telehealth conference with other members of the care team (and optionally, the patient) once a patient's GPMP has been approved. The Schedule Telehealth Conference action becomes available in the patient's demographics area.

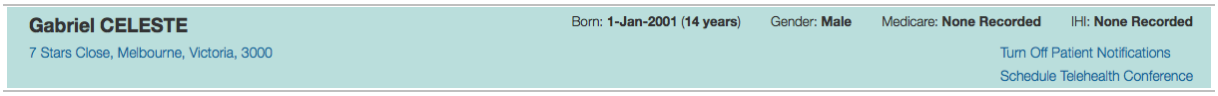


Figure 84. Schedule Telehealth Conference Action

Before scheduling a Telehealth Conference, ensure that all participants:

- Are registered with cdmNet and are part of the patient's care team;
- Have the necessary equipment: a webcam, microphone and reliable Internet;
- Are available for the desired date and time; and
- Ideally, have already downloaded and installed the WebEx Meeting Centre client.

Where participants do not have a microphone, you will need to organise a separate phone call with the participant(s).

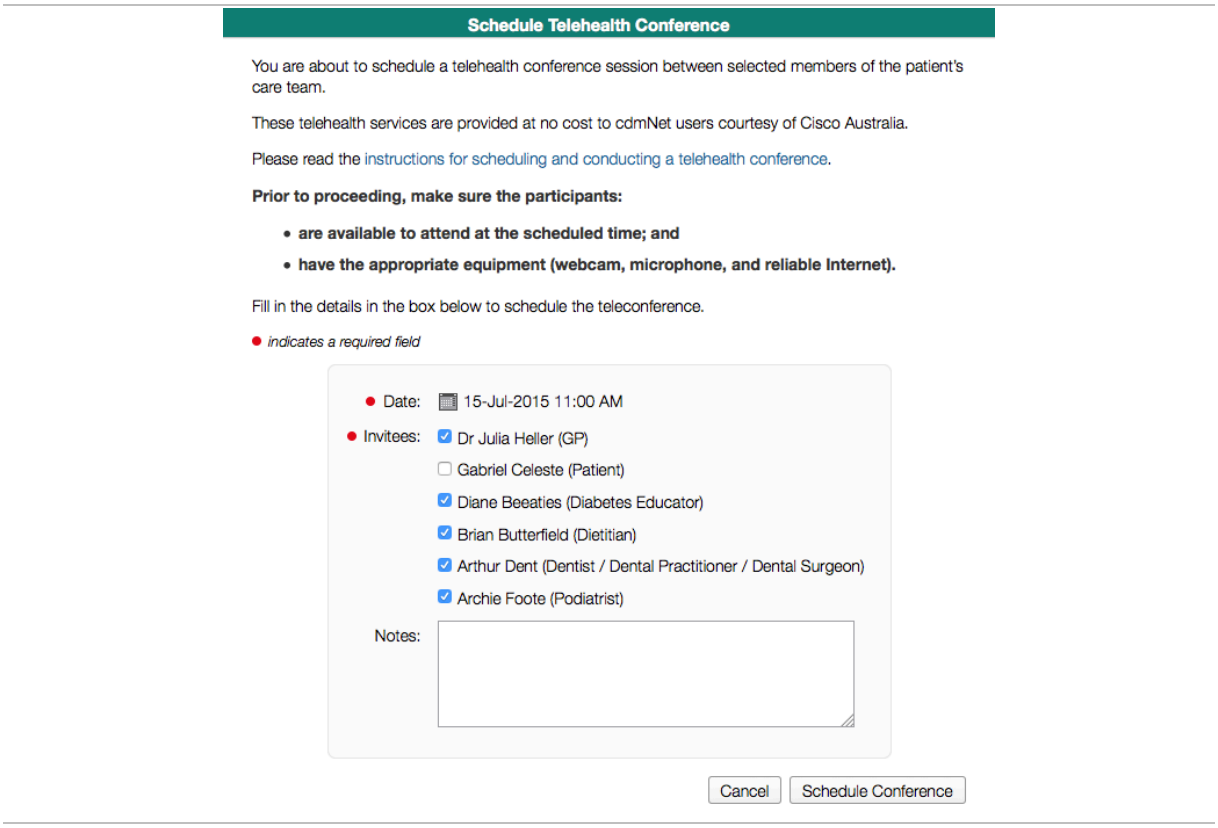


Figure 85. Scheduling a Telehealth Conference

By default, all care team members are listed for invitation to the conference, and you must untick any invitee who you do not wish to receive the emailed notice of the conference. Click the calendar icon to change the time and date of the conference. Once you are happy with the arrangement for the telehealth conference, click Schedule Conference; cdmNet displays a confirmation message. cdmNet notifies all invitees who can be contacted electronically that you have scheduled a telehealth conference. Any invitee who does not have a form of electronic contact (email, SMS) will need to be contacted manually.

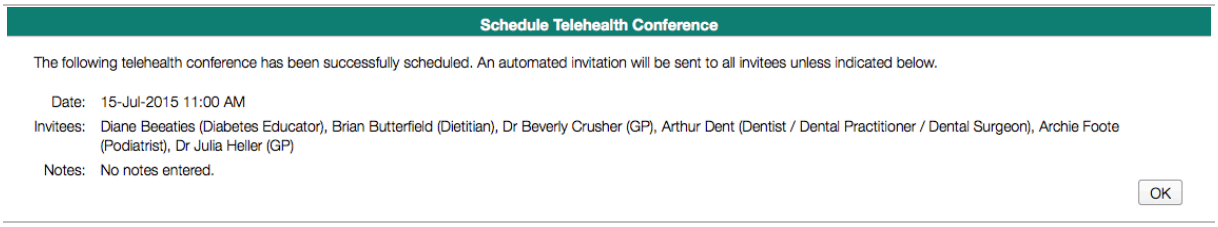


Figure 86. Telehealth Schedule Confirmation Message

Once the scheduling of the conference is confirmed, a new entry appears in the Progress Notes. A basic summary of this note also appears on the Overview page.

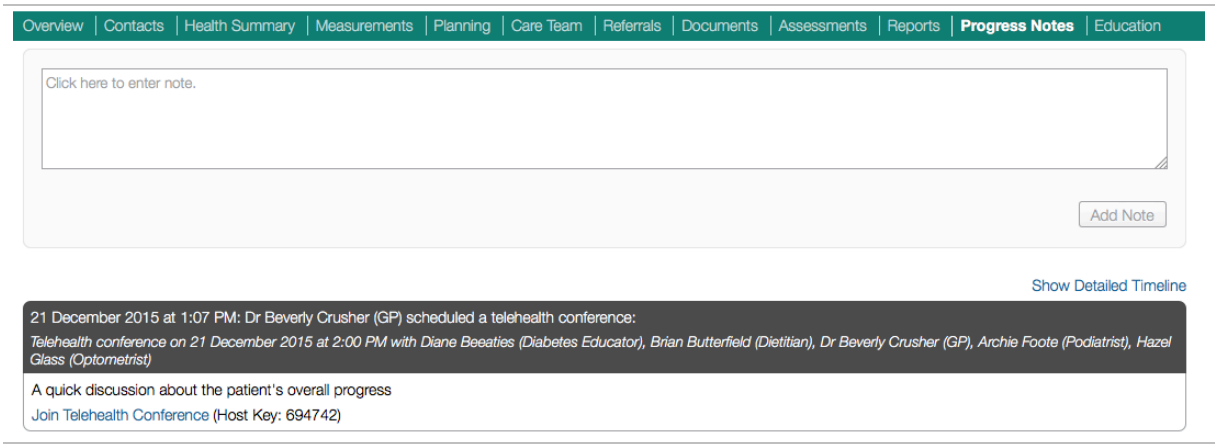


Figure 87. Telehealth Conference Schedule Note Entry in Progress Notes

If you need to change the scheduled time of the telehealth conference or add or remove a participant, simply reschedule a new telehealth conference. Upon rescheduling, you could add a note indicating the changes.

If you need to cancel a telehealth conference, contact cdmNet Support at **cdm.net.au/support**.

At the time of the scheduled telehealth conference, you can click the Join Telehealth Conference link from the Progress Notes entry or from the link in the automated confirmation message which takes you directly to WebEx.

Note that when using this service for the first time, after clicking the blue Join button, you may be prompted to download and install the WebEx Meeting Centre client to engage in the telehealth conference. You may need to re-join the conference after doing this.

If you are the host, join the telehealth conference as above. You may need to enter the Host Key, which is displayed next to the Join Teleheath Conference link and also provided in the automated confirmation message. To reclaim host privileges, select Reclaim Host Role from the Participant menu in the WebEx menu bar and enter the host key when prompted. This starts the conference.

To start sharing your video, click the camera icon (it turns green). To start a voice conference, click the headphones icon or select Integrated Voice Conference from the Audio menu and click Start Conference. The microphone icon to the right of the window should be grey, not red.

When you have finished the telehealth conference, click End Meeting at the bottom of the window or from the File menu.

For more information about WebEx, including tips for troubleshooting connection problems or audio/video difficulties, visit **http://webex.com.au/howto**

9.5 Care Team TCA Agreements

Once a Team Care Arrangement has been created and cdmNet has notified the care team members, it is up to them to agree to it.

A minimum of two agreements is required in order to continue to the next stage.

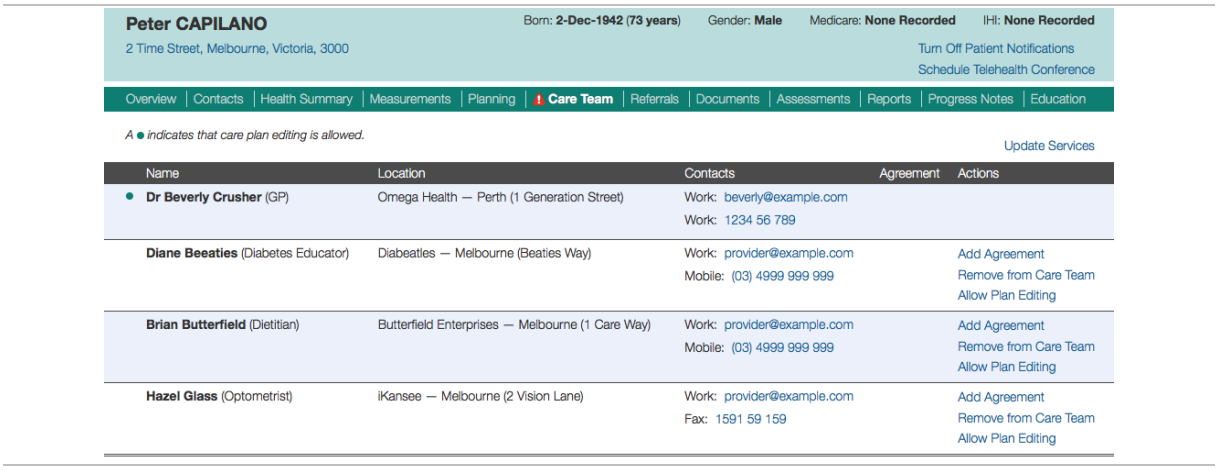


Figure 88. Team Care Arrangement Awaiting Care Team Agreement

While it is recommended that all care team members agree to the TCA independently, you can agree to their part in the agreement on their behalf, provided that you have consulted with them about it. To do this, click Add Agreement and tick the box to confirm that you have consulted with the provider.

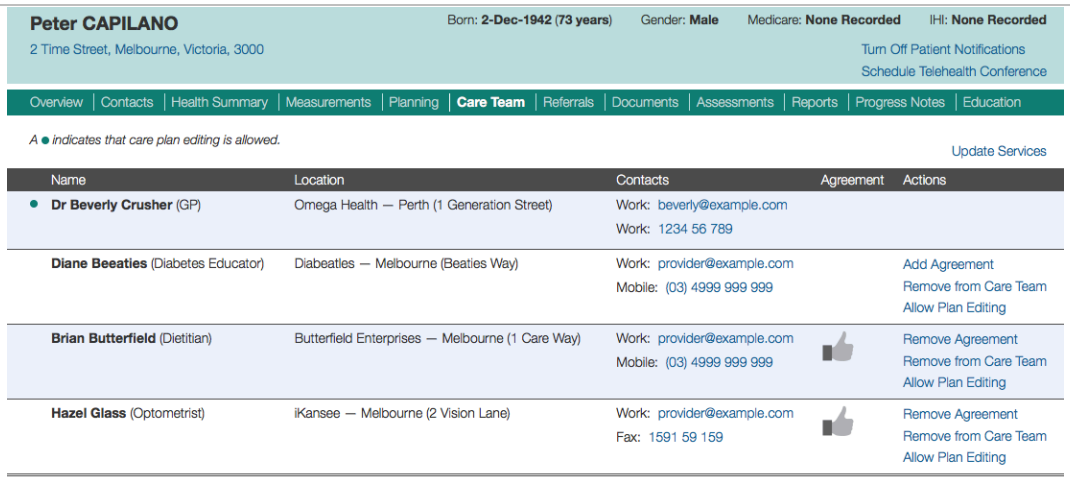


Figure 89. TCA Agreed — Pending Approval

Once you have enough agreements from your Care Team Members, you can approve the TCA by clicking Approve TCA from the Planning page or the Overview page.

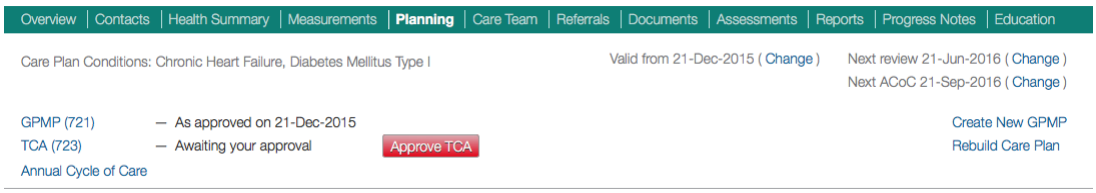


Figure 90. Approve TCA from Planning Page

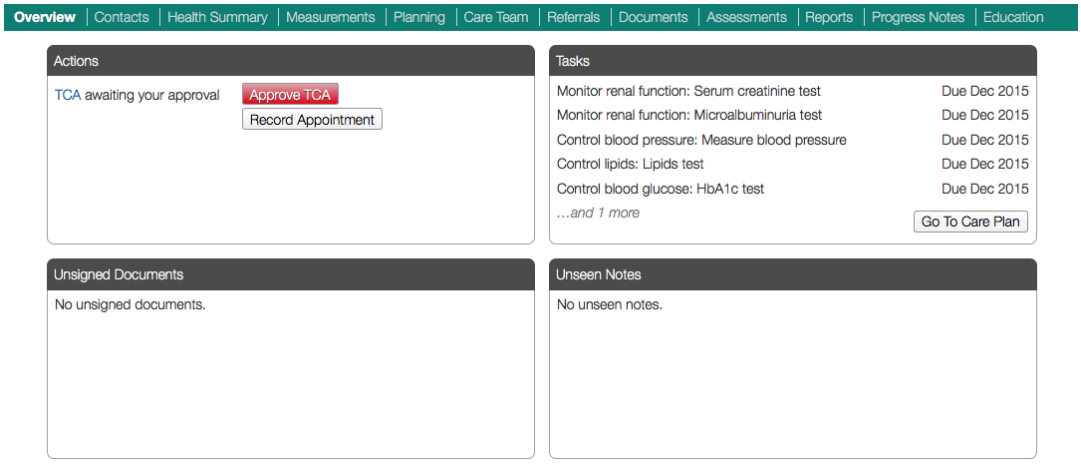


Figure 91. Approve TCA from Overview Page

If you are a Care Plan Creator, you are approving the TCA on behalf of the Primary Care Provider.

If you are a Primary Care Provider and nominated as a Care Plan Creator for the patient's Primary Care Provider, as well as a member of the same organisation, you are approving the TCA in your own right.

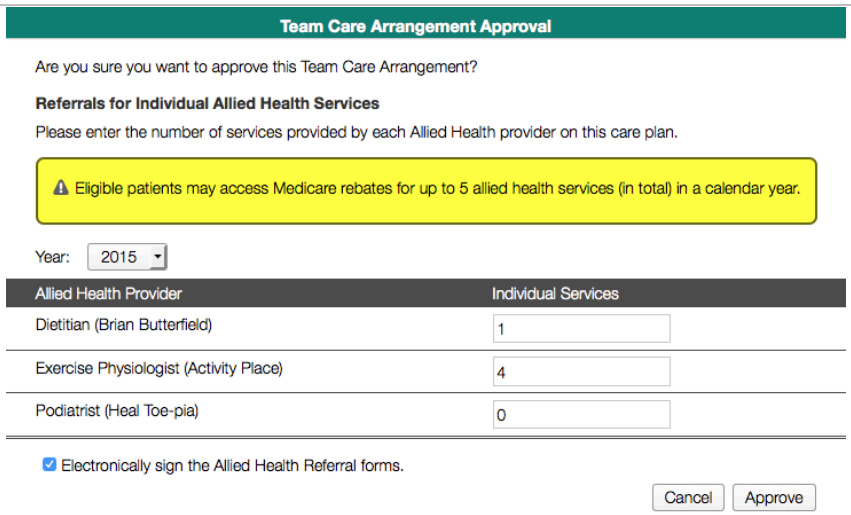


Figure 92. TCA Approval

As a PCP or CPC, you need to determine how many services the Allied Health Providers can provide the patient per year. As per Medicare rules, up to 5 services may be provided in total. You may select the following year to which the services may be applied. Allied Health Referral Forms are only generated if you allocate services to the Allied Health Providers.

If the patient is of Aboriginal or Torres Strait Islander descent, cdmNet presents the option to include Indigenous Allied Health services here.

Note that you can only electronically sign the Allied Health Referral Forms if you are the Primary Care Provider, or another Primary Care Provider nominated as a Care Plan Creator for the patient's Primary Care Provider, as well as a member of the same organisation. Once you have approved the TCA, PDF files for MBS item 723 and supporting documents (Allied Health Forms) become available in the Documents page.

9.5.1 Signing Documents

If you untick the box to Electronically sign the Allied Health Referral Forms (or similar for any Home Medicines Review Referral Forms), it simply means that the documents created are not electronically authenticated. You can sign them electronically from the patient list by finding the patient (using the 'patients with unsigned documents' filter if appropriate) and clicking the Sign Documents action in the Actions column. (You can, of course, sign the documents manually on paper, if you wish.) You can also electronically sign documents from the Overview page (in the Unsigned Documents widget).

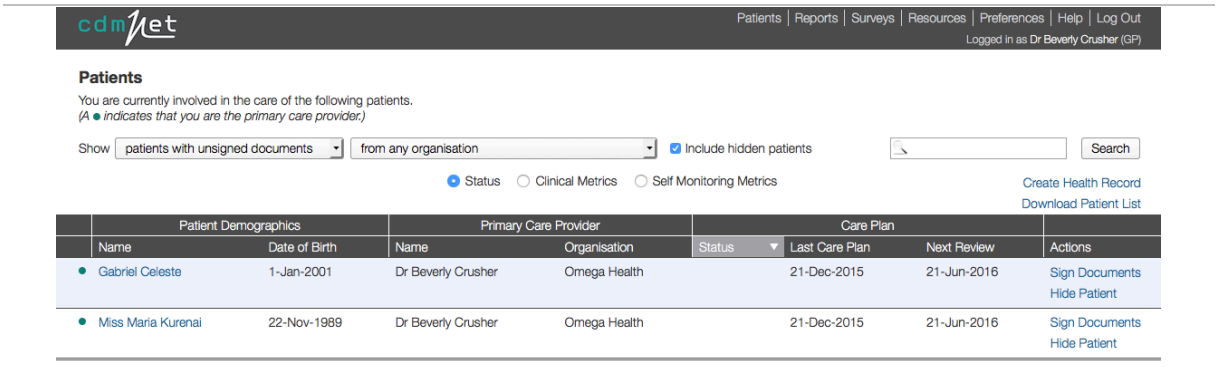


Figure 93. Patient List Filtered by Patients with Unsigned Documents

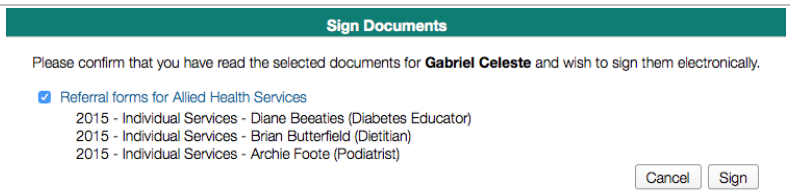


Figure 94. Sign Documents

9.5.2 Leaving the Care Team

If you are assigned to a patient but do not wish to participate in their care, for whatever reason, find the patient in your patient list and click the Leave Care Team action in the Actions column. When you use the Leave Care Team action, a note appears on the Progress Notes page, indicating that you have left the care team.

9.6 Reviewing GPMPs

As a PCP or CPC, it is up to you to review the GPMP when the review date approaches. On the patient list, you can select the filter 'patients awaiting action from you' to see patients who may be due for a GPMP Review.

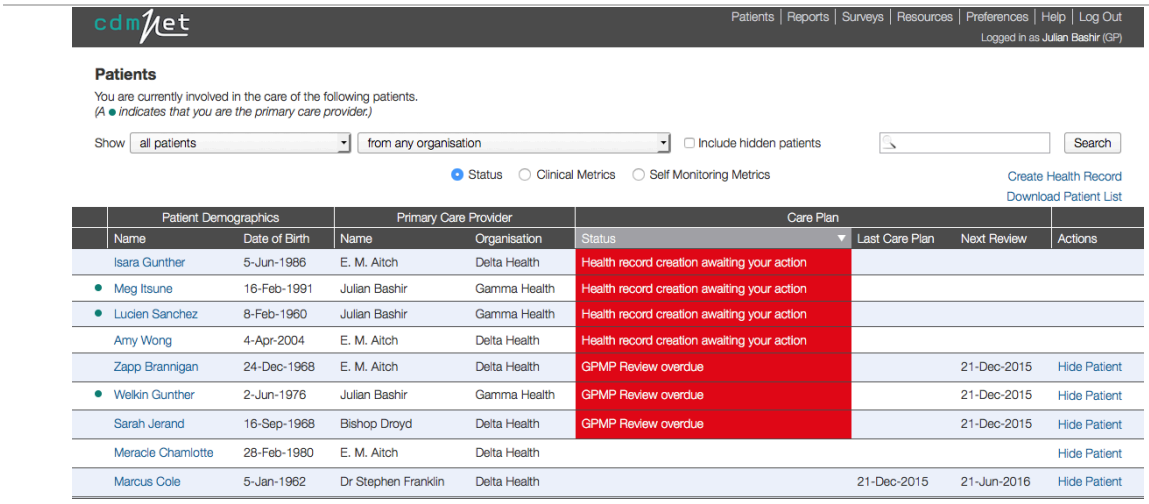


Figure 95. Patient List Showing GPMP Review Overdue

The Commence GPMP Review link becomes available on a patient's record one month before the review date that was set when the GPMP was approved.

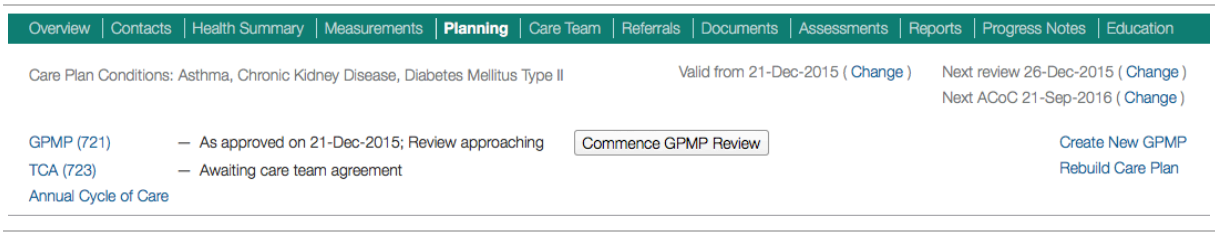


Figure 96. GPMP Review Approaching

This is a good point to review the patient's progress while making modifications to the care plan if appropriate (by entering new tasks and goals onto the Planning page or clicking Rebuild Care Plan to get cdmNet to generate any proposed changes to the care plan for you).

Clicking Commence GPMP Review initiates the review process, displaying a screen where you can quickly review whether all due or overdue tasks in the care plan were completed, as well as recording any measurements that are needed.

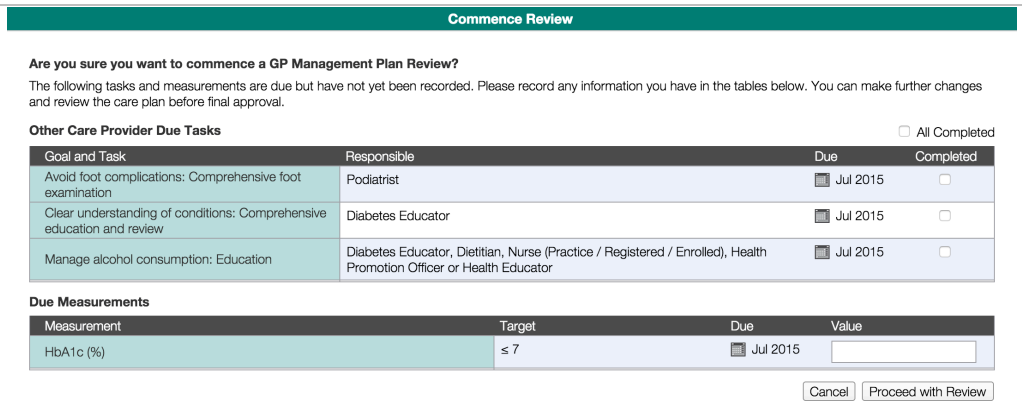


Figure 97. Commence GPMP Review

Once the GPMP review has been initiated, it is up to the PCP or CPC to approve it.

When approving a document, if you are a Care Plan Creator, then you are approving it on behalf of the Primary Care Provider. However, if you are another Primary Care Provider nominated as a Care Plan Creator for the patient's Primary Care Provider, as well as being a member of the same organisation, then you are approving the document in your own right.

(You may need to adjust the review date and ACoC in order to comply with the Medicare rules.)

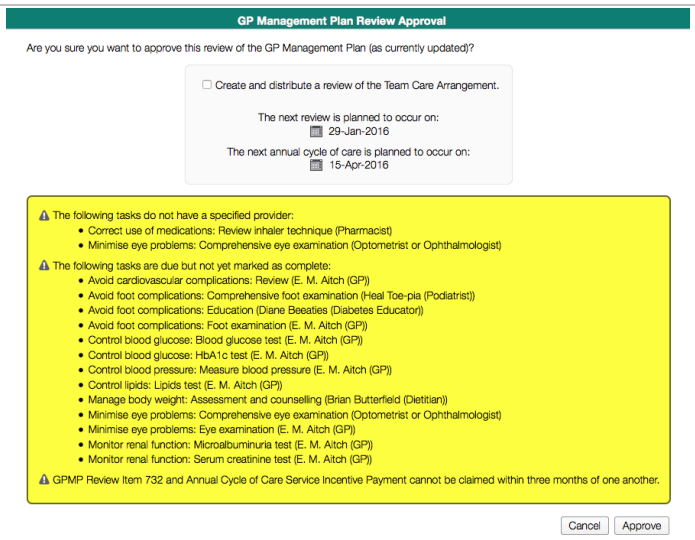


Figure 98. GPMP Review Approval

When the GPMP Review has been approved, the GP Management Plan Review form 732 becomes available in the Approved Care Plans section of the patient's Documents Page.

If you have previously prepared a Team Care Arrangement for the patient, and you tick 'Create and distribute a review of the Team Care Arrangement' when

approving the GPMP review, cdmNet notifies the care team that a TCA Review has commenced and needs their agreement.

9.7 Reviewing TCAs

As with TCAs, the TCA Review also needs a minimum of two agreements from care team members in order to continue. This time, however, cdmNet shows the agreements with another grey hand with thumbs up and a green tick.

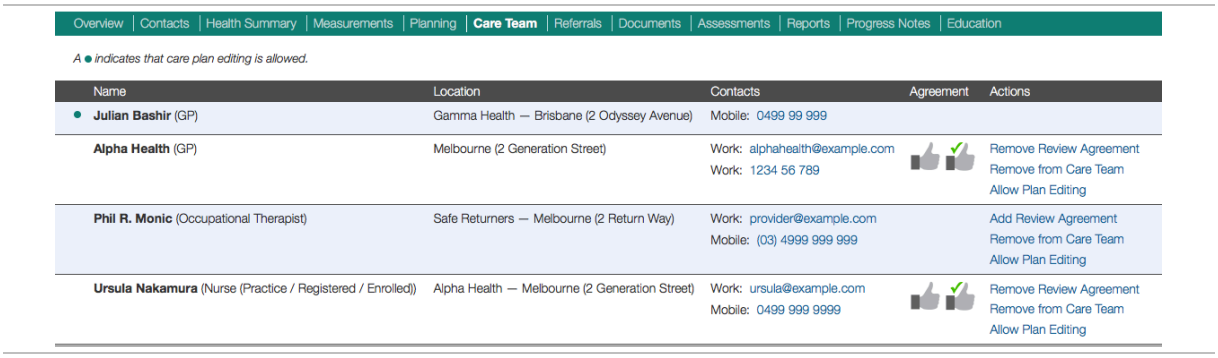


Figure 99. TCA Review With Review Agreements

Once two care team members have agreed to the TCA Review, you can approve it (as the PCP or CPC) from the Planning or Overview page.

If you have not already generated Allied Health referral forms for the current year, you are prompted to do so when approving the TCA Review. It is up to your discretion to allocate the number of services that Allied Health members can provide to the patient, applicable to the current or following year.

If the patient is of Aboriginal or Torres Strait Islander descent, cdmNet presents the option to include Indigenous Allied Health Services here.

When the TCA Review has been approved, the Team Care Arrangement Review form 732 is available on the patient's Documents Page.

9.8 Annual Cycles of Care

At the time of writing, cdmNet supports the Annual Cycle of Care for Diabetes only.

You can view the current progress against the ACoC by clicking Annual Cycle of Care in the top section of the Planning page when viewing a patient's health record. This opens a new window displaying the information in a PDF file.

The information presented in the ACoC is based on the progress of the patient's care plan. cdmNet automatically calculates appropriate dates to include in the ACoC corresponding to the history of appointments and measurements shown on the Planning page.

You can approve an ACoC within a month of the 'Next Annual Cycle of Care' date by clicking Approve ACoC.

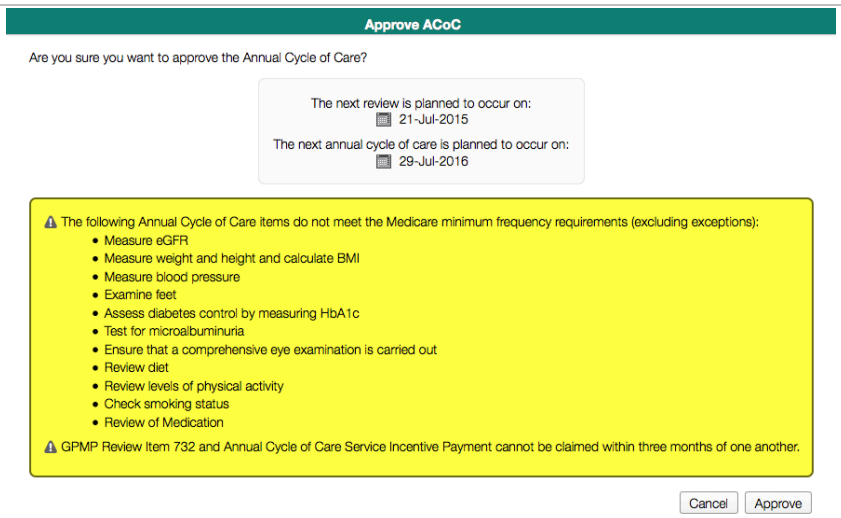


Figure 100. Approve Annual Cycle of Care

A yellow warning box appears if there are areas in the ACoC that may not meet the Medicare minimum frequency requirements.

Should you have any further questions about using cdmNet or how it works, please contact our Support team by visiting **cdm.net.au/help**.

10 Glossary

Term	Definition
ACoC	Annual Cycle of Care: A yearly program of care for managing diabetes. cdmNet only supports annual cycles of care for diabetes.
APCP	Associated Primary Care Provider: A CPC who is also a PCP and a member of the same organisation as a patient's Primary Care Provider. APCPs can construct and manage care plans with the ability to approve documents in their own right, as well as electronically signing supporting documents such as Allied Health Forms.
CPC	Care Plan Creator: A provider who can construct and manage care plans on behalf of a PCP.
GPMP	General Practitioner Management Plan: A plan devised by the PCP or CPC to manage a patient's chronic disease(s).
HPI-I	Health Provider Identifier for Individuals: A unique number that identifies an individual who provides health care services.
HPI-O	Health Provider Identifier for Organisations: A unique number that identifies an organisation that provides health care services.
IHI	Individual Health Identifier: A unique number that identifies an individual such as a patient.
PCP	Primary Care Provider: The main care provider responsible for a patient, who constructs and manages care plans.
PHC	Precedence Health Care Pty Ltd: The creators, developers and operators of cdmNet.
Provider	Someone with a speciality in the medical field who is associated with Patients, Organisations and Care Plans – for example, they might be a GP, Podiatrist, Diabetes Educator.
Service Provider	Someone with a non-medical speciality – for example, they might be Laundry, Shopping, Respite.
TCA	Team Care Arrangement: An arrangement of Care Team Members assigned to a patient to see to tasks on a care plan.
WebEx	An online portal where scheduled conferences are held.

11 PHC Partners

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