

SAMPLE CHECKLIST TO ASSIST IN SETTING UP A Systematic Approach to CDM

Aspect	Key Questions	✓
Demographic details	What is the patient profile? Are there many patients with specific chronic diseases?	
	What can a Clinical Audit Tool data analysis tell us?	
	Can we identify our patients with chronic diseases e.g. diabetes?	
	Can we identify those asthma patients with moderate to severe asthma?	
	Which chronic disease initiatives could be utilised for this practice population?	
	Can we identify the patients who may benefit from HMR?	
	What one area will we address initially?	
Clinical issues for GPs and Nurses	Do I know about the Asthma Cycle of Care?	
	Do I know about the Diabetes Annual Cycle of Care?	
	Do I know about the Better Access, ATAPS and Mental Health Shared Care programs?	
	Can our practice utilise other staff members in managing chronic disease?	
	What new roles and skills are required in the practice to improve our CDM?	
	Do I know about the Medicare Chronic Disease Management (CDM) items and initiatives?	
	Do we know who we can refer to for Team Care Arrangements?	
	What Allied Health Professionals do we have onsite?	
	Do we need to set aside blocks of time for care planning?	
	Am I implementing Quality Use of Medicines / best-practice guidelines in the treatment of patients?	
	What is the role of the Practice Nurse in CDM?	
What can be claimed through MBS for PN work?		
Administration	Is this practice registered for Practice Incentive Payments?	
	Do we know when we can claim for PIPS / SIPS?	
	Do we have good clinical data and record keeping?	
	Is the patient data base "clean"?	
	Are active, inactive, deceased, patient details and diagnosis coded correctly?	
	Do I have a Diabetes Register of diabetic patients?	
	Do I have a patient recall / reminder system?	
	Am I registered with Medicare Australia for diabetes, asthma or cervical screening SIPs?	
	Do we have appropriate templates for care planning on our clinical software?	
	Do we know how to import other templates into our system from websites?	
	Do we have all the forms required and do we need access to electronic forms?	
	Who will be involved in identifying patients that would benefit for care planning?	
	Who will send letters to patients and maintain records of responses?	
	Does the practice need to consider training for staff and/or employing a Practice Nurse?	
	Do staff have appropriate resources to perform duties?	
Does the Practice Nurse have access to computer and a room to consult patients?		

Administration cont.	For HMR – do we know the referral process to a community pharmacy or accredited pharmacist?	
	Does the practice have access to relevant resources/patient information?	
	Has the practice established links and communication processes with relevant service providers?	
	Do staff know how to complete billing and item number process?	
Patients	How do we inform the patients of our chronic disease management processes?	
	Who will decide which patient group to target?	
	Booking appointments – check with whom and the amount of time to be allocated?	
	Do we want to have specific patient clinics for established diseases?	
	Are all missed recall appointments followed up? How is this recorded?	
Getting Started	Take a continuous improvement approach in implementing CDM within the practice. Use the PDSA approach - Plan, Do, Study & Act.	
	Plan: Plan your goals so you know where you are going, what, who, when, where, predictions & data to be collected. Start small.	
	Do: Undertake the activities that you planned. Document any unexpected problems or outcomes.	
	Study: Have you achieved your targets and goals? Review and reflect on results. What feedback have you obtained along the way to improve what you do next time?	
	Act: What will you take forward from this cycle? Based on the feedback at the “Study” stage, make improvements; reset the goals and targets.	