Sparked

HL7 FHIR

Clinical Design Group

Wednesday 19th February 2025

Adelaide

Acknowledgement of Country

We acknowledge the Traditional Custodians of the land on which we all gather today.

We pay our respect to elders past, present, and emerging and extend our respect to all Aboriginal and/or Torres Strait Islander people, acknowledging the First Peoples as the first scientists, educators and healers.
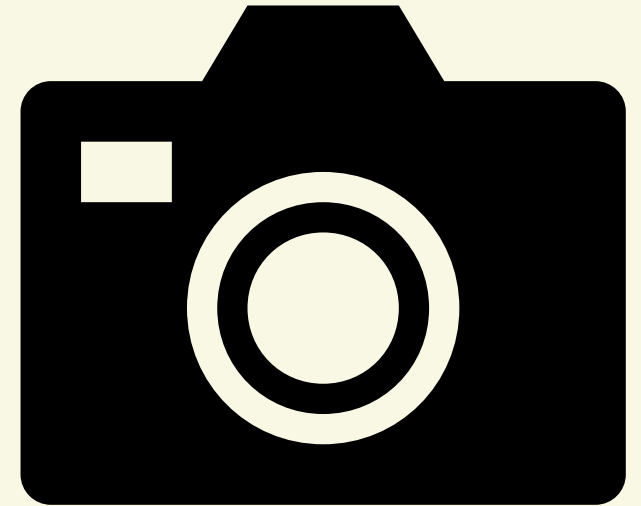
Photos/Video

Please be advised that photographs and video will be taken at the event for use on our website and in other written and online publications.

By entering this event, you consent to the photography and video and using your image and likeness.

If you do not wish to be photographed or videoed, please inform the Sparked team.

Time	Topic	
9:00am	Welcome and introductions	Kate Ebrill
9.10am	Objectives	Kate Ebrill
General Updates		
9.20am	Department of Health and Aged Care Update	DOHAC
9.35am	Australian Digital Health Agency Update	ADHA
SA Showcase		
9.50am	South Australia Digital Health Update Deadalus amPHi Project	Alastair McDonald Stacey Clifford/ Peter Moltzen Juul (Dedalus)
10.30am	Morning tea	
Chronic Condition Management (CCM)		
11am	Introduction	DOHAC
11.15am	Perspectives	Oliver Frank Jackie O'Connor Nicola Mountford Deanna Connor Marc Belej
11.45am	Chronic Condition Wheel Data Group Overview	Nyree Taylor
11..55am	Example Chronic Condition Management Plan Template	Liam Barnes
12.10pm	Workshop 1 – CCM	Kate Ebrill

Time	Topic	
12.45pm	Lunch	
Reason for Encounter/Encounter Summary		
1.30pm	Introduction to Encounter Summary/Reason for Encounter	Kylynn Loi/ Kate Ebrill
1.40pm	Encounter Summary/Reason for Encounter Panel

Panel discussion on the value of an Encounter Summary | Kate Ebrill (Moderator)

Jeremy Sullivan Vicki Bennett Charlotte Hespe Chris Moy |
2.10pm	Workshop 2 – Encounter summary/Reason for encounter	Kate Ebrill/Kylynn Loi
3.00pm	Afternoon tea	
AU Patient Summary/Patient Story		
3.30pm	Patient Summary Update (AUCDI and AU PS FHIR IG)	Kylynn Loi/Danielle Tavares-Rixon
3.40pm	ADHA update	Ricardo Inacio
3.50pm	Perspectives	Mehmet Kavlakoglu Grahame Grieve Harry Iles-Mann
4.10pm	Workshop 3 – Patient Story	Kate Ebrill/ Ricardo Inacio
4.45pm	Next steps and wrap up	Kate Ebrill
5pm	CDG concludes	

Spar H

Objectives

✅ Updating the CDG on the AUCDI Release 2, AU Patient Summary

✅ Understand requirements for Shared Care Plans and Chronic Condition Management

✅ Understand requirements for Reason for Encounter and Encounter Summary

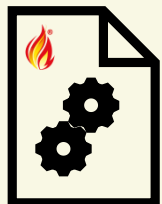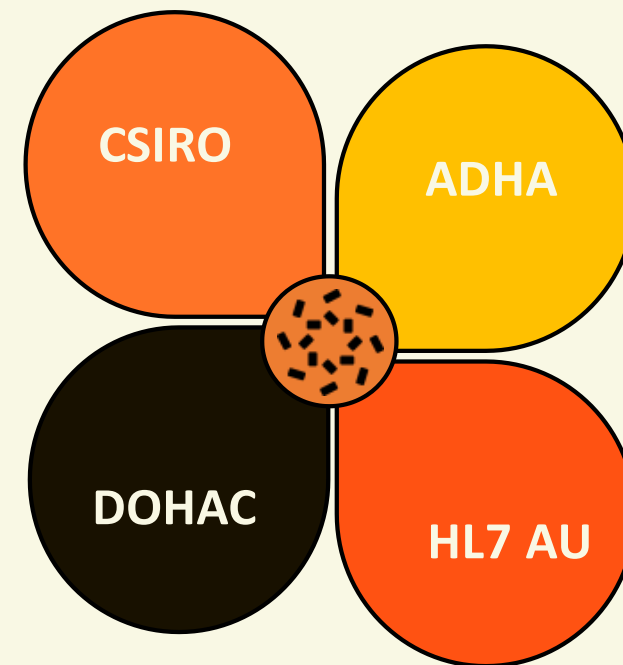✅ Explore the idea of Patient Story in the Patient Summary Context

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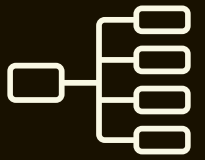
Sparked Accelerator Scope

Meaning & Context	**Language & Terms**	**Sharing & Exchange**	**Testing**	**Implement**

Data for Interoperability (e.g. AU CDI)

- AU CDI - R1 - Published
- AU eReqDI -Published
- AU CDI R2 – in development
  - Patient Summary -Public Comment
  - Chronic Condition Management -Public Comment- February

Clinical Terminology Value Sets

- SNOMED CT and LOINC Value sets RANZCR
- RCPA

FHIR Implementation Guides

- AU Core -Published AU eRequesting Ballot for comment AU Patient Summary In development

Testing & Piloting of FHIR Standards

- Testing of FHIR Standards, supported by infrastructure & tooling

Reference Implementations & Testing Service
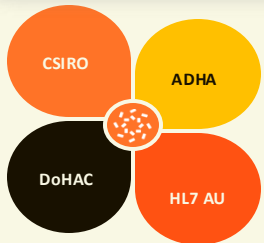
- Services that support implementation and testing of FHIR based applications

AU CDI R3 - in planning

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What is AU Core and Australian Core Data set for Interoperability (AUCDI)?

CDG is here

AU CDI
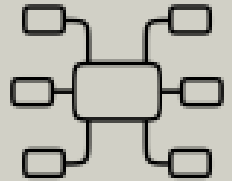
Specifies *"WHAT"* **clinical information** (and corresponding data elements and terms) should be included for data entry, data use and sharing information supporting patient care

TDG is here

AU Core
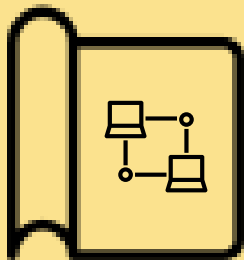
Specifies *"HOW"* the core set of data (above) and information should be **structured, accessed** and **shared** between systems

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AUCDI Release 2 Chronic Condition Management

Release 1

"Core of the core"

Concepts for a health summary (guided by clinical content of IPS)

Release 2

Patient summary

Chronic Condition Management

Reason for Encounter

Release 3

AUCDI – iteratively growing

*CDG scoping and requirement gathering for future releases

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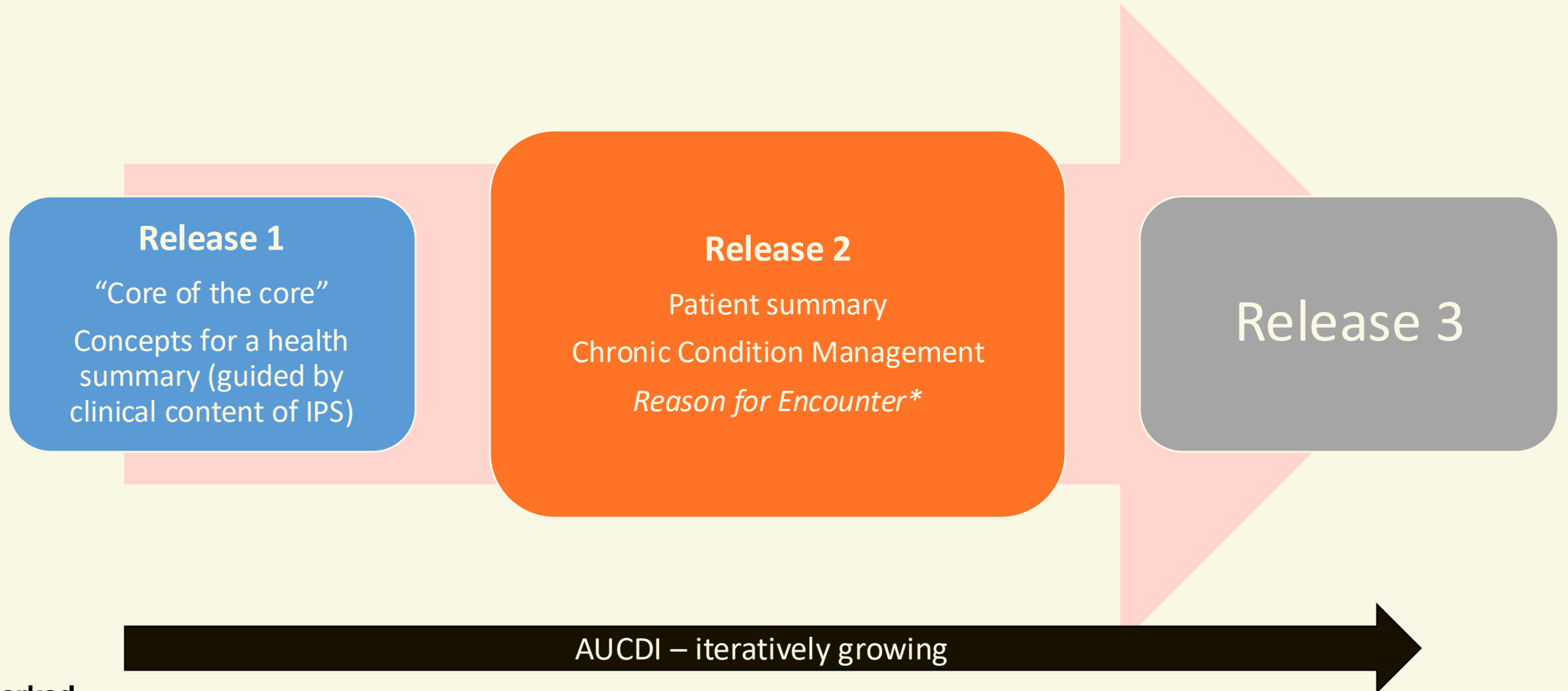
AUCDI Release 2 – Chronic Condition Management

Health Issue
- Issue name
- Description
- Date of onset
- Last updated

Goals
- Goal name
- Description
- Clinical indication
- Initiator role
- Initiator
- Start date
- Proposed end date
- Actual end date
- Outcome
- Comment
- Last updated

Service request (generic)
- Service name
- Clinical indication
- Clinical context
- Urgency
- Service due
- Comment
- Distribution list
- Urgent contact
- Billing guidance

Substance use summary
- Substance name
- Overall status
- Overall comment
- Last update

Tobacco smoking summary
- Overall Status
- Last updated
- Type
  - Status
  - Typical use
  - Comment
- Overall quit date
- Overall years of smoking
- Overall pack years
- Overall comment

Alcohol consumption summary
- Overall status
- Overall comment
- Last update

Procedure completed
- Procedure name
- Description
- Body site/laterality
- Clinical indication
- Date performed
- Comment

Health education
- Education topic
- Description
- Date/time provided

Medical equipment supply
- Equipment type
- Description
- Date/time provided

Psychosocial therapy
- Therapy type
- Description
- Date/time provided

Physical assistance
- Assistance type
- Description
- Date/time provided

Education summary
- Overview
- Highest level completed
- Last updated

Financial summary
- Overview
- Financial stability status
- Last updated

Food and nutrition summary
- Overview
- Food security status
- Last updated

Housing summary
- Overview
- Housing stability status
- Last updated

Living arrangement summary
- Overview
- Last updated

Occupation summary
- Overview
- Employment status
- Last updated

Physical activity summary
- Overview
- Last updated

Proposed scope AUCDI R2 CCM

New content for AUCDI Release 2 are noted in black text
Service request brought across from AUeReqDI R1

AUCDI Release 2 Chronic condition Management

- Draft for community comment out for review early April

- Really interested to get the communities feedback

- Lots of new ground covered
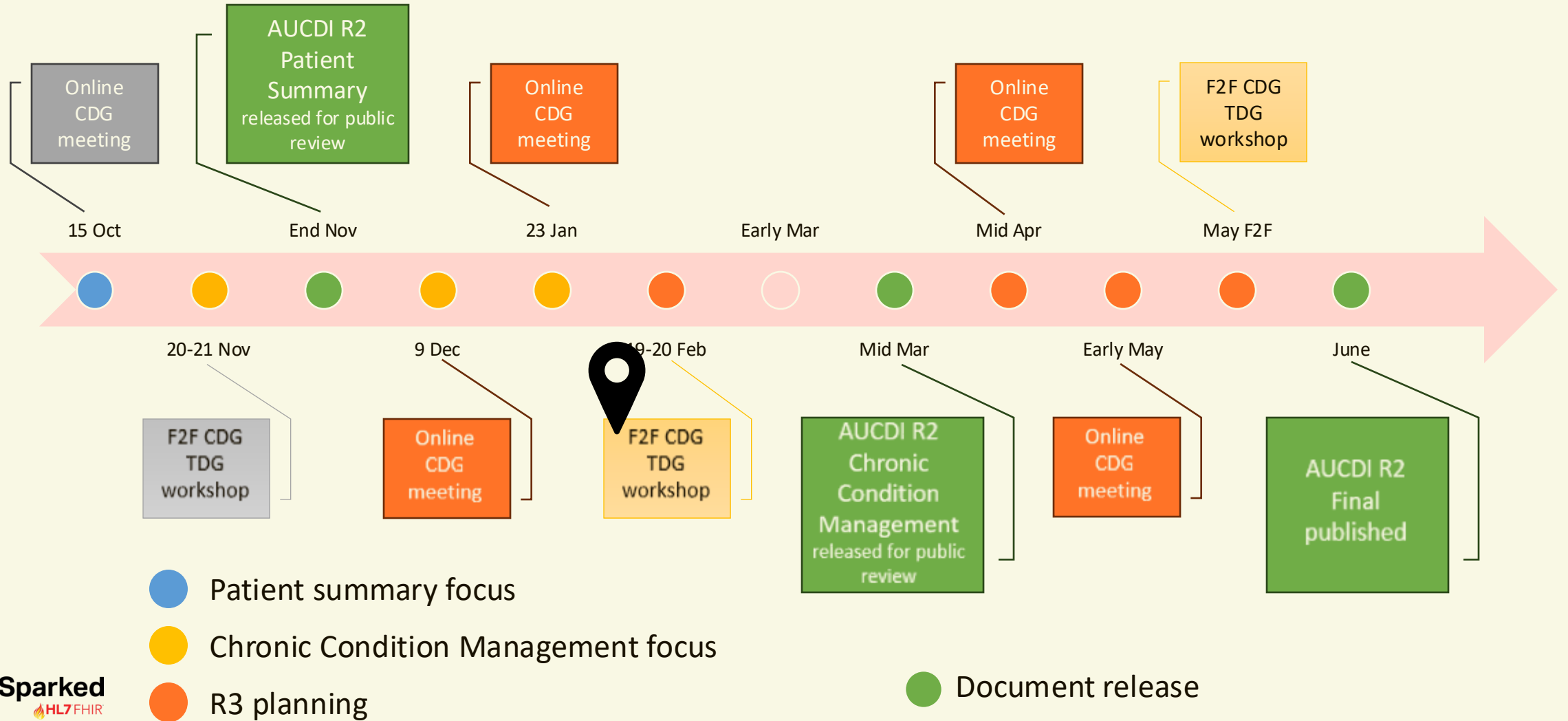
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AUCDI R2 schedule

Above timeline (top row):

- 15 Oct — Online CDG meeting
- End Nov — AUCDI R2 Patient Summary released for public review
- 23 Jan — Online CDG meeting
- Early Mar
- Mid Apr — Online CDG meeting
- May F2F — F2F CDG TDG workshop

Below timeline (bottom row):

- 20-21 Nov — F2F CDG TDG workshop
- 9 Dec — Online CDG meeting
- 19-20 Feb — F2F CDG TDG workshop
- Mid Mar — AUCDI R2 Chronic Condition Management released for public review
- Early May — Online CDG meeting
- June — AUCDI R2 Final published

Legend:

- 🔵 Patient summary focus
- 🟡 Chronic Condition Management focus
- 🟠 R3 planning
- 🟢 Document release

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Department of Health and Aged Care

Building the future on FHIR

Australian Government
Australian Digital Health Agency

Adelaide

19 February 2024

Peter O'Halloran
Chief Digital Officer

Health Legislation Amendment (Modernising My Health Record—Sharing by Default) Bill 2024

Type	Government
Portfolio	Health and Aged Care
Originating house	House of Representatives
Status	Passed Both Houses
Parliament no	47

Track

(What's this?)

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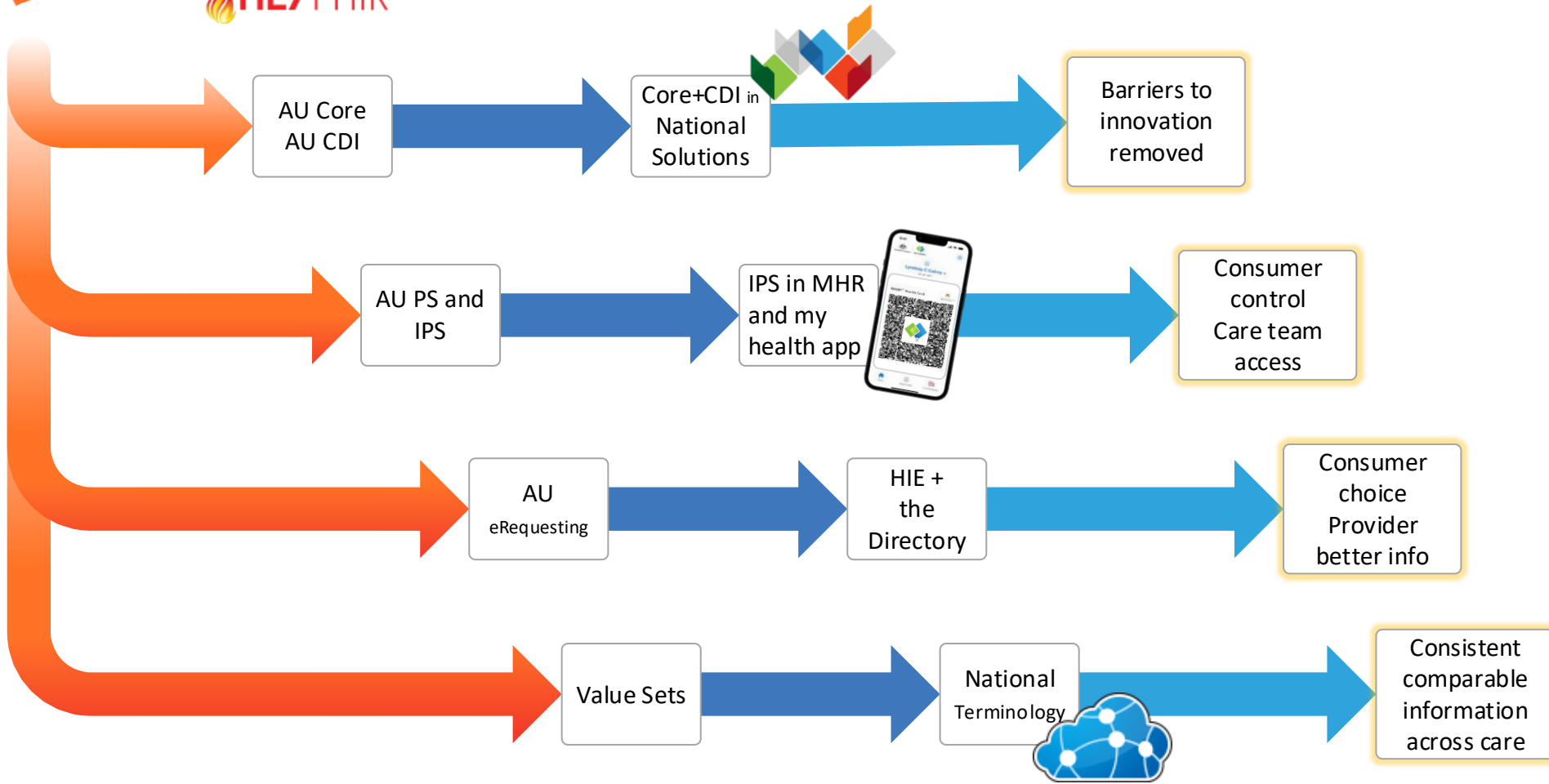
South Australia Showcase:
Alastair McDonald
(SA Health)

Sparked Clinical Design Group

Version 1.0

18 February 2025

Digital Health SA

Government of South Australia
SA Health

2 December 2024 – HIB Incident

12 February 2025 – Sharing by Default

30 March 2025 – Statewide EMR

OFFICIAL: Sensitive

Integration Architecture – Current State

Technology Core

- EMR/PAS
- ESMI
- Community & Mental Health
- EPLIS
- Health Information Broker
- Objective Records mgt
- Aged Care
- Oracle Financials
- Patient IDs EMPI

Enterprise Network & Infrastructure
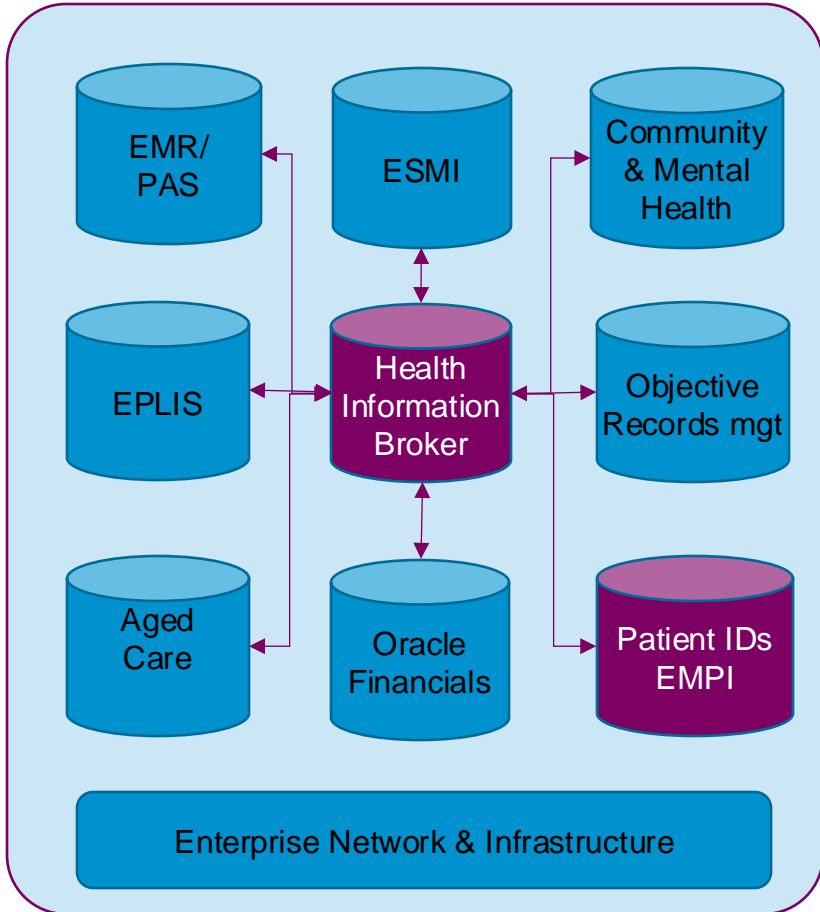
Digital Enablers
(Data & Interoperability)

Data Analytics Platform DAP

mHR → Secure Messaging → eReferrals
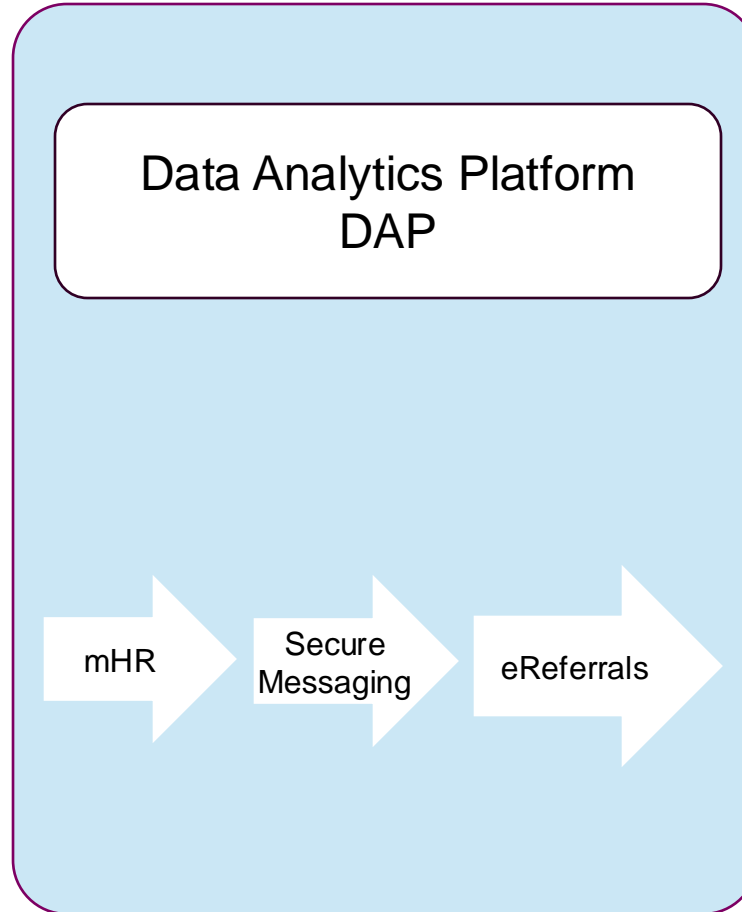
Digital Customer
Experience & Insights
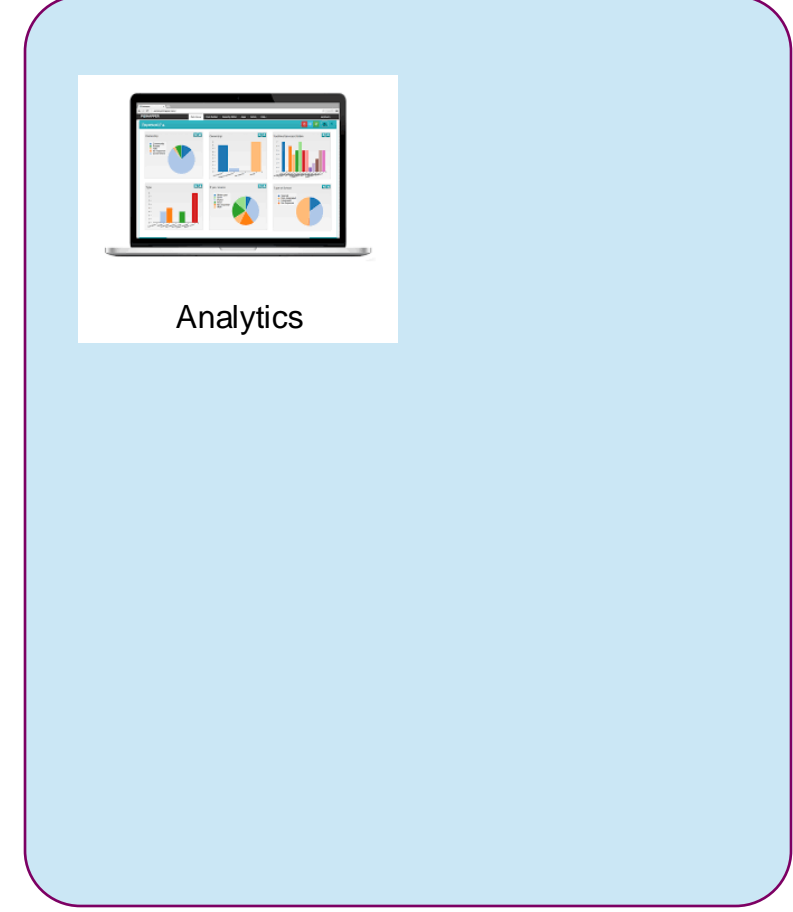
Analytics

Interoperability Architecture – Target State

Technology Core

- EMR/ PAS
- ESMI
- Community & Mental Health
- EPLIS
- Oracle Financials
- Objective Records mgt
- Aged Care

Enterprise Network & Infrastructure

Digital Enablers
(Data & Information Exchange)

Data Analytics Platform DAP

Interoperability Architecture

EMPI

Cloud HIB

Systems of Engagement
Customer experience & Insights

Analytics

Interoperability Architecture – Target State

Technology Core

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- Aged Care

Enterprise Network & Infrastructure

Digital Enablers
(Data & Information Exchange)

Data Analytics Platform DAP

Interoperability Architecture

- Clinical terminology
- Provider Registry(s)
- National identifiers
- EMPI
- Cloud HIB

Systems of Engagement
Customer experience & Insights

Analytics
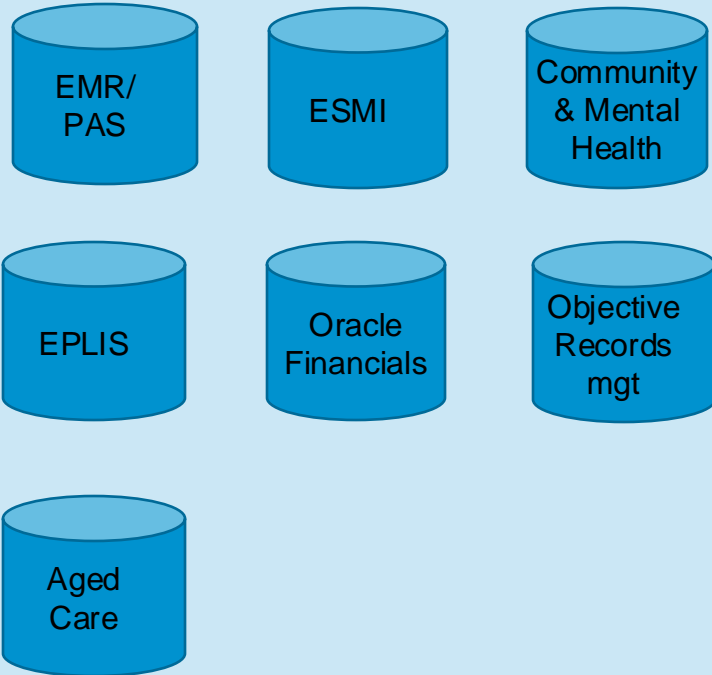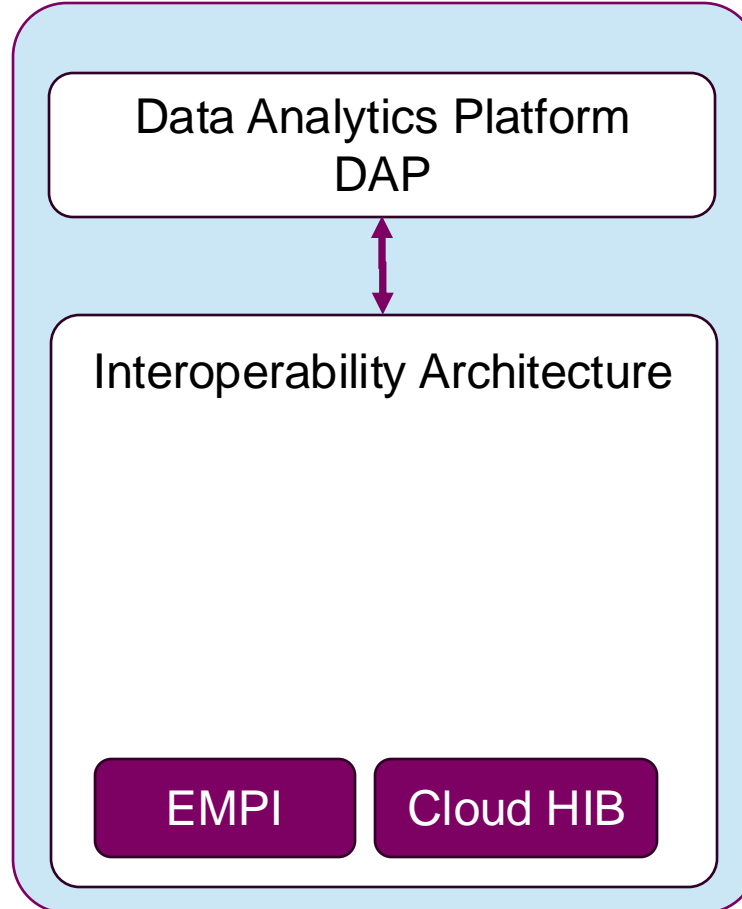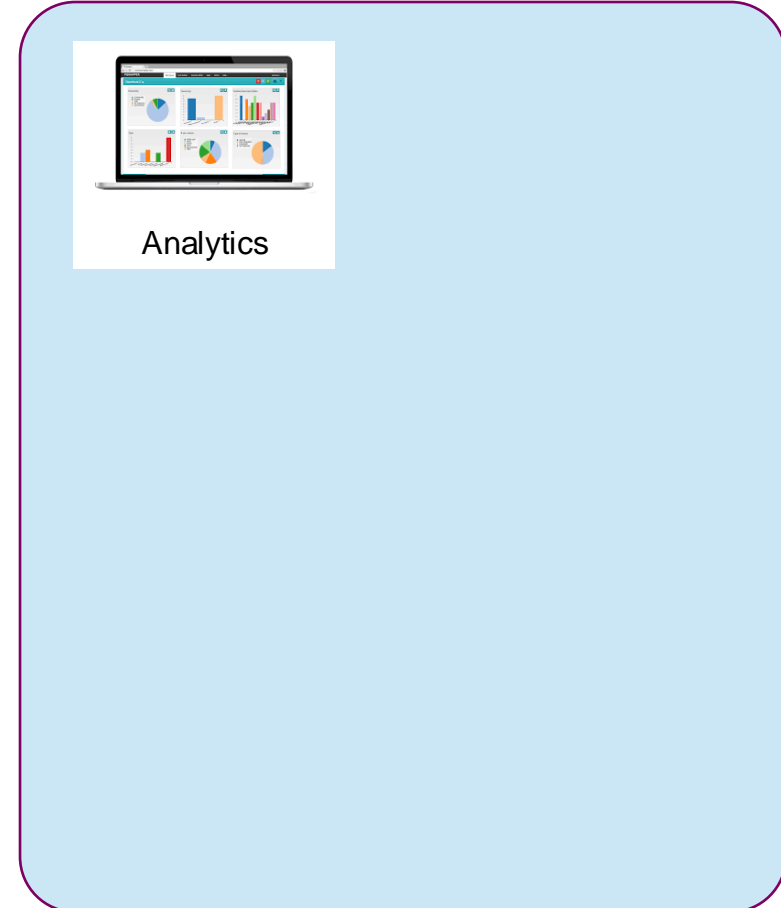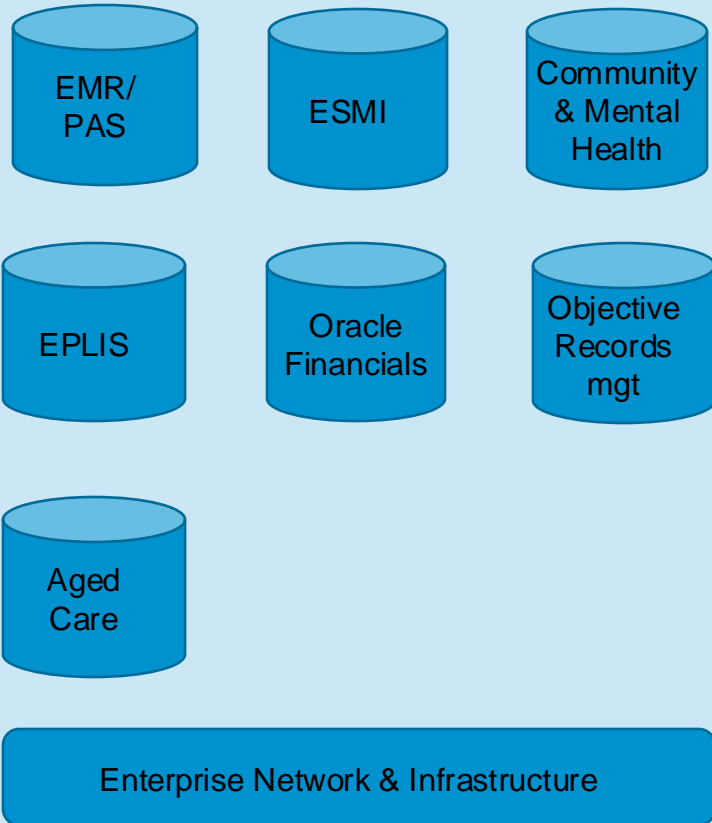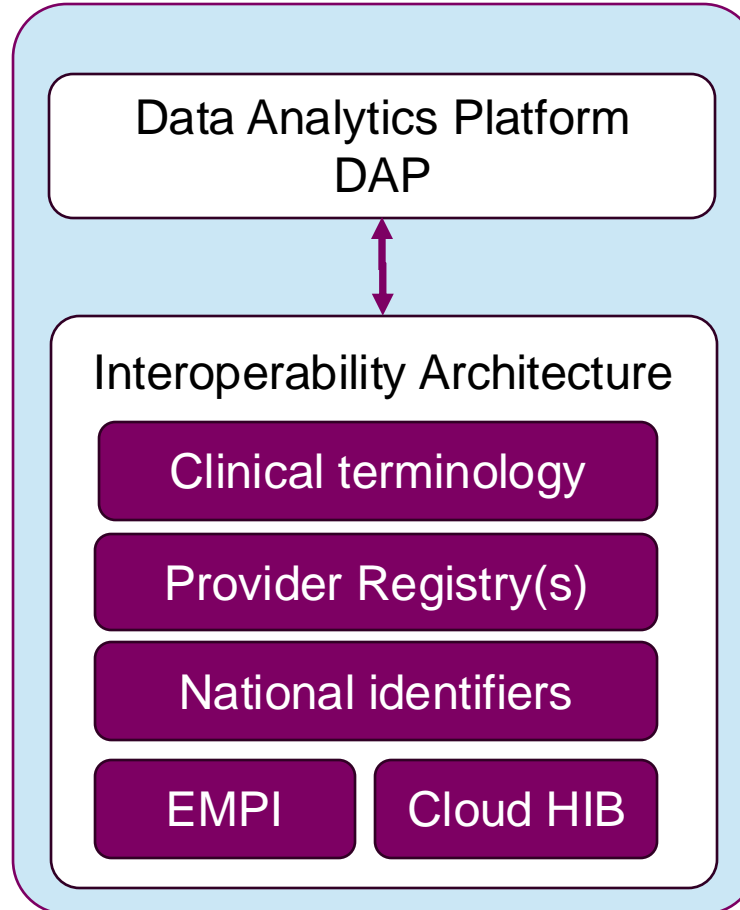
Interoperability Architecture – Benefits realisation

Technology Core
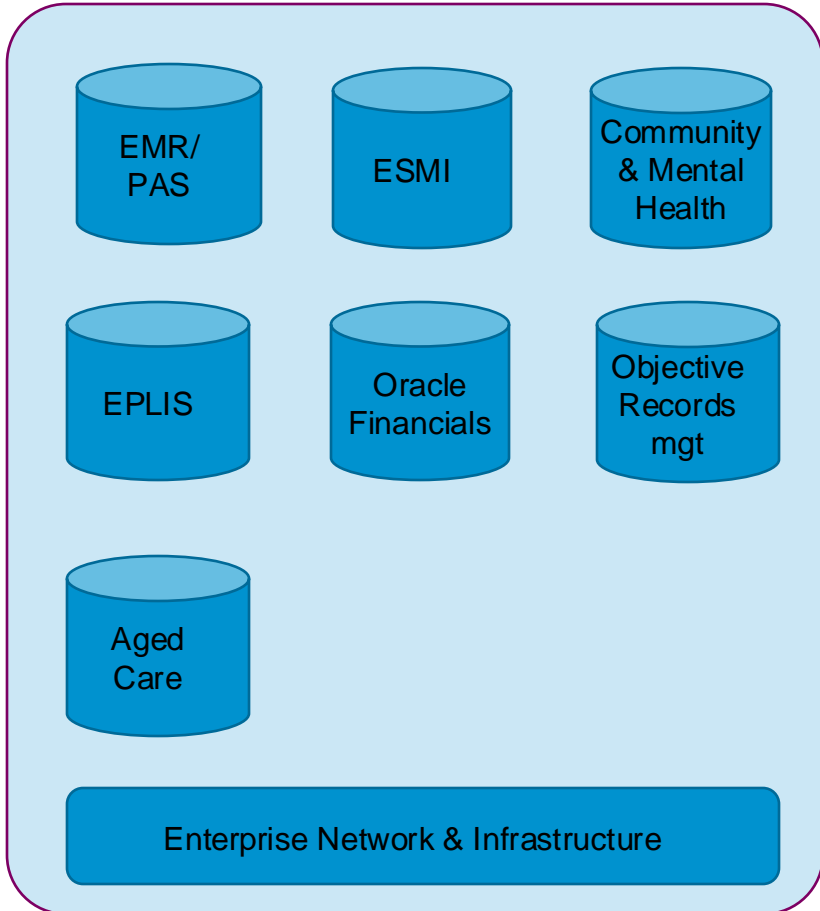
- EMR/PAS
- ESMI
- Community & Mental Health
- EPLIS
- Oracle Financials
- Objective Records mgt
- Aged Care

Enterprise Network & Infrastructure

Digital Enablers
(Data & Information Exchange)

Data Analytics Platform DAP

↕

Interoperability Architecture

- Clinical terminology
- Provider Registry(s)
- National identifiers
- EMPI
- Cloud HIB

Systems of Engagement
Customer experience & Insights

Analytics

Insights

Consumer Apps

Remote Monitoring

Clinical Apps

HIE

Primary Care
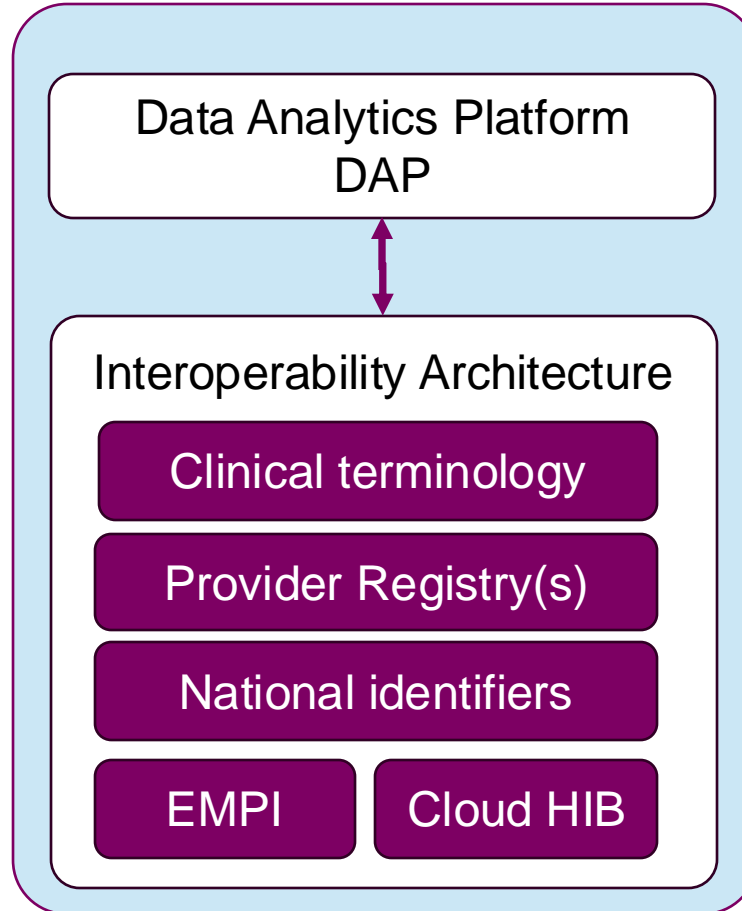
Interoperability Architecture – Foundation for innovation & change

Technology Core

- EMR/PAS
- ESMI
- Community & Mental Health
- EPLIS
- Oracle Financials
- Objective Records mgt
- Aged Care
- SA Ambulance Service

Enterprise Network & Infrastructure

Digital Enablers
(Data & Information Exchange)

Data Analytics Platform DAP

Interoperability Architecture

- Clinical terminology
- Provider Registry(s)
- National identifiers
- EMPI
- Cloud HIB

Systems of Engagement
Customer experience & Insights

- Analytics
- Insights
- Consumer Apps
- Remote Monitoring
- Clinical Apps
- HIE
- Primary Care

**Government
of South Australia**

SA Health

South Australia Showcase:
Stacey Clifford
& Peter Moltzen Juul
(Dedalus)

amPHI is a best of breed prehospital ePCR solution with a vision to close the gap between ambulance care and in-patient outcomes.

- amPHI is a prehospital ePCR developed in Denmark in response to the need for more coherent patient processes, to increase data quality and patient security, and meaningfully; allow efficient recording and data sharing

- In Australia we have a fantastic opportunity to utilise intraoperability within amPHI, to draw and share key patient data to support prehospital clinicians in gaining an improved view of the patient at the time of incident and contribute meaningfully to ongoing patient care.
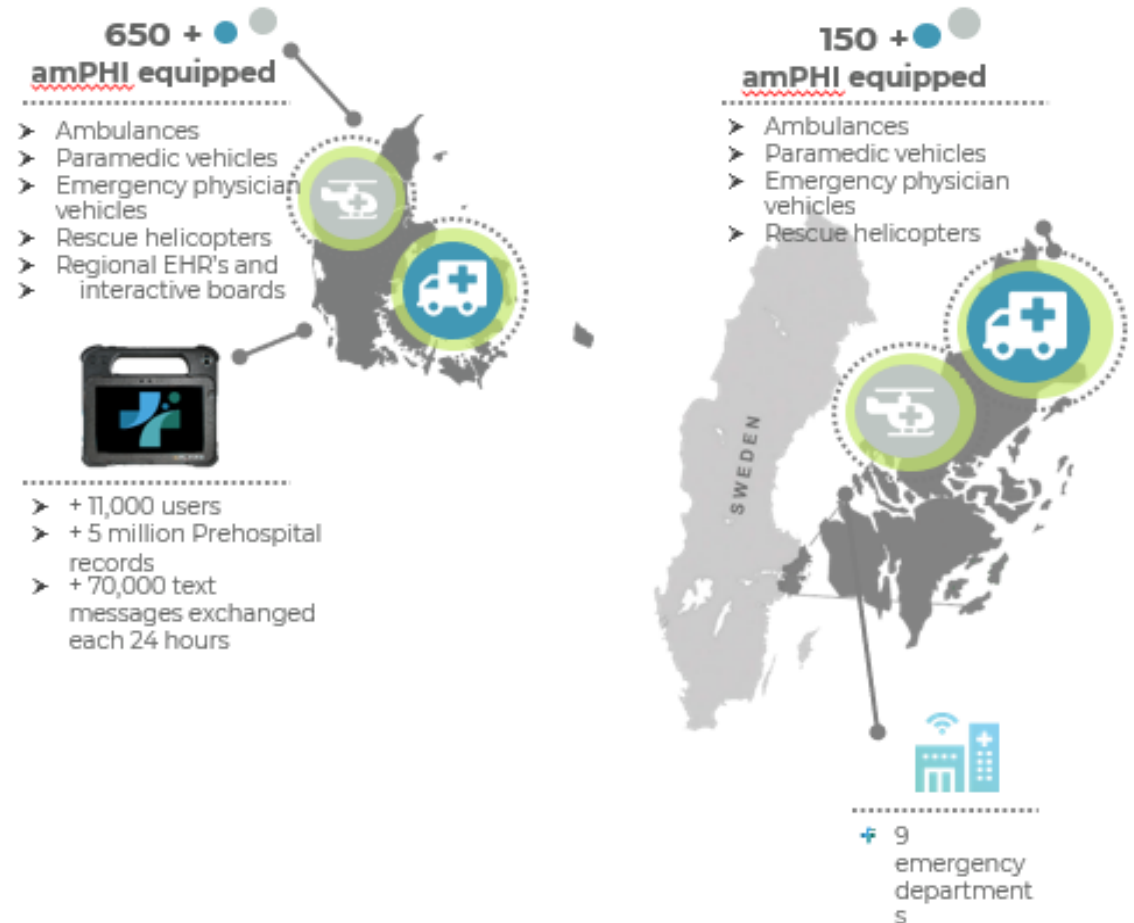

650 +
amPHI equipped
➤ Ambulances
➤ Paramedic vehicles
➤ Emergency physician vehicles
➤ Rescue helicopters
➤ Regional EHR's and
➤   interactive boards

➤ + 11,000 users
➤ + 5 million Prehospital records
➤ + 70,000 text messages exchanged each 24 hours

150 +
amPHI equipped
➤ Ambulances
➤ Paramedic vehicles
➤ Emergency physician vehicles
➤ Rescue helicopters

SWEDEN

+ 9 emergency departments

1. Higher acuity intervention is commencing with in Ambulances now, that was once only available as inpatient care.
2. Early access to patient allergies, previous diagnosis, and home medications can aid prehospital teams in best determining the appropriate care
3. Increased demand for better utilisation of clinical responding teams

- Standardised nomenclature (such as SNOMED CT AU & ICD10) to record information such as allergies, presenting complaint & provisional diagnosis to:
  - Bridge the gap with external health data bases for data exchange
  - Provide a structured digital handover in a format digestible to EMR systems.
  - Supporting transition of care

- Standardised formats for patient demographics to support PPID matching and secure integration of patient histories within the ambulance.
  - Supporting clinical decision making to inform most appropriate care
  - Provide an opportunity to act in accordance with chronic care plans

Enhancing Healthcare Interoperability with amPHI, FHIR, AU Core, and SNOMED CT AU

- As the project focuses on integrating various healthcare systems to ensure seamless data exchange and interoperability, the use of standardised data sets and FHIR APIs is essential to allow this to occur effectively. With this in mind amPHI is leveraging FHIR, AU Core, and SNOMED CT AU to enhance healthcare interoperability and data sharing.
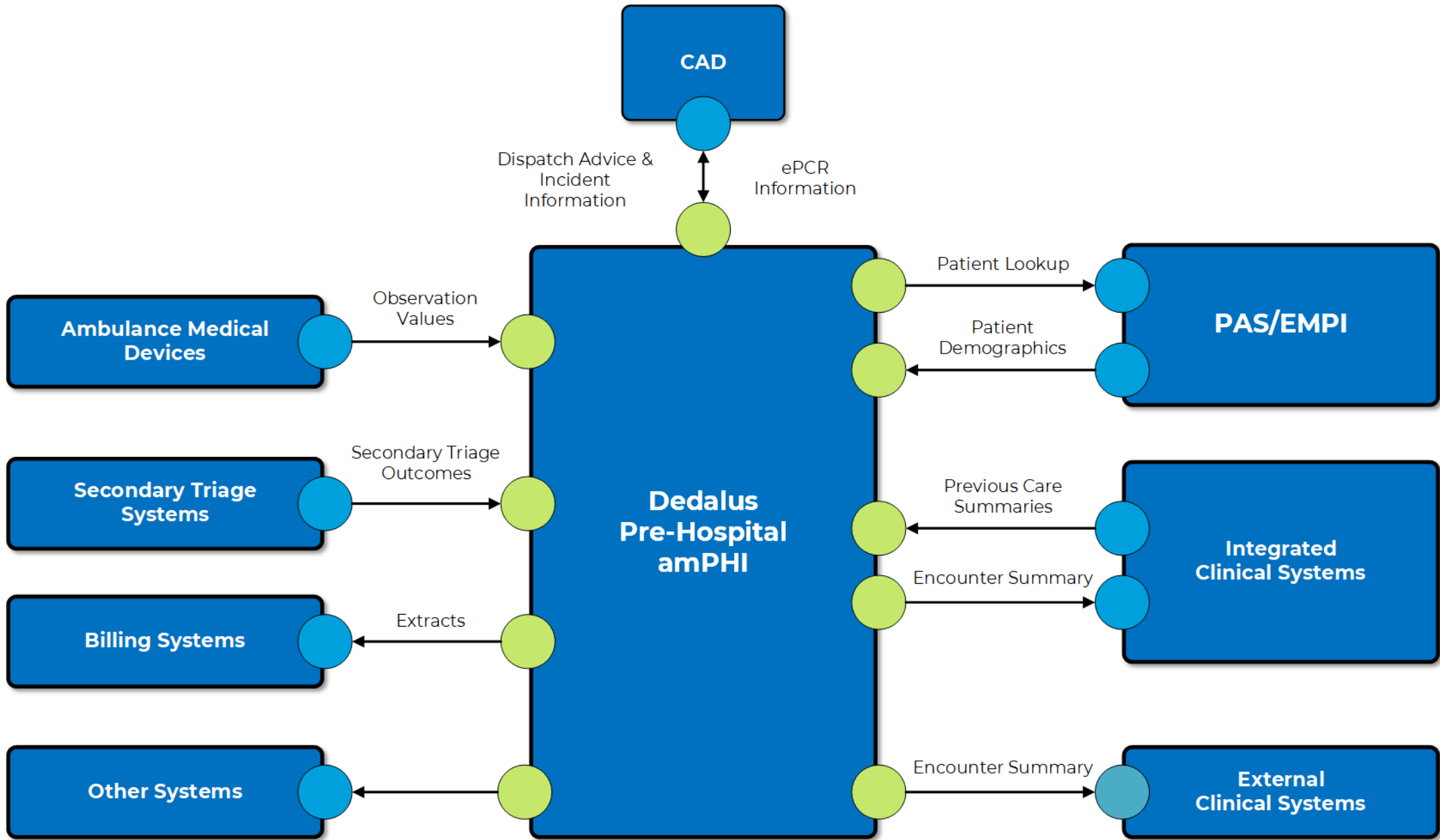
Integration with FHIR

- amPHI has developed a detailed FHIR Interface Specification, which includes profiles for Patient, MedicationStatement, Condition, AllergyIntolerance, and more.
- This integration allows for real-time data sharing and updates, ensuring that clinicians have access to the most current patient information as it happens within the pre-hospital environment.

FHIR AU Core

- Whist much of the system already has many of the FHIR interfaces, amPHI's Roadmap's goal is to expose all of amPHI data through defined FHIR interfaces, enabling real-time sharing of Patient Record information, Incident information, and Ambulance information, this ensures that data is shared in compliance with Australian standards, such as ICD10, SNOMED, and NEMSIS standards, ensuring alignment with Australian-specific FHIR profiles of AU Core.

Incorporating SNOMED CT AU

- SNOMED CT AU for consistent and accurate representation of clinical information, that supports better clinical decision-making and enhances the quality of patient care.

Dedalus

#TOGETHER4SUCCESS

Conclusion

- The amPHI project is making significant strides in enhancing healthcare interoperability through its integration with FHIR, AU Core, and SNOMED CT AU, and these efforts are crucial in ensuring that healthcare providers have access to accurate and up-to-date information, ultimately improving patient care and outcomes.
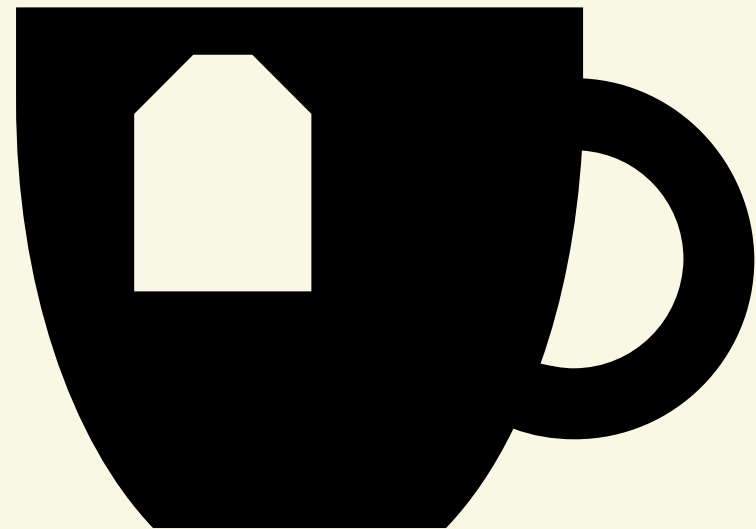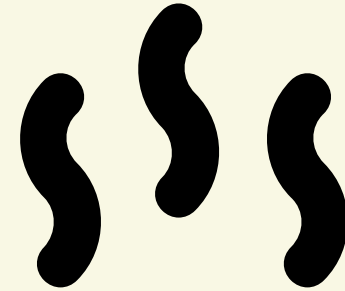
Chronic Condition Management

Perspectives: Oliver Frank (General Practice)

PLEASE NOTE: Some slides have been updated following the presentation

Challenges and opportunities in the care of people with chronic conditions

Dr. Oliver Frank MBBS PhD CHIA FRACGP FAIDH
Specialist general practitioner
Oakden Medical Centre
Hillcrest, Adelaide

Clinical Associate Professor
Discipline of General Practice
Adelaide Medical School
University of Adelaide

Sparked CDG 19th February 2025

What do people with chronic conditions need from health professionals?

Education about their condition, including:

- how it relates to and interacts with other aspects of their health and its care

- their own potential role in their care

A plan for their care including:

- their own goals, needs and abilities

- professional targets and goals

- their progress towards those goals

- automated reminders about actions that are due

What do health professionals need when caring for people with chronic conditions?

An easy to access and easy to update overview or dashboard of the agreed plan for care, the person's progress and their outcomes

The overview of a person's chronic condition should include:

The person's own reports of progress, their own actions, their satisfaction with their care and unmet needs or wishes

Who is caring for the person

Who is in charge of or managing the person's care: the person themselves or a relative, friend, carer, agency or service

PLEASE NOTE: This slide has been updated following the presentation

The overview of a person's chronic condition should include:

The services that health professionals and others are providing

Funding support available:

- source (Medicare, NDIS, compensation, private health insurance, self, other)

- total amount available in what period

- how much of that funding has been claimed or used to date

PLEASE NOTE: This slide has been updated following the presentation

The overview of a person's chronic condition should include:

Dates of all past and future appointments related to this condition

Dates on which referrals need to renewed (if renewal is appropriate)

All communications with or about the person

PLEASE NOTE: This slide has been updated following the presentation

Automated monitoring and support

Conformance of care to current guidelines

New knowledge, especially for patients who have one of the 10,000 "rare" conditions suffered by 1 in 12 people

Prompts, alerts, warnings and advice about new assessments, investigations, appropriate referrals and treatments

https://www.racgp.org.au/afp/2015/september/rare-diseases-are-a-common-problem-for-clinicians

Current challenges

For GPs, providing care of people's chronic conditions is complex because:

- Many people have multiple chronic conditions

- GPs also have to advise, offer and provide or arrange all recommended preventive care

- People also have acute conditions

Lack of formal patient enrolment inhibits GPs from taking responsibility and for being rewarded for providing quality care

Referrals to relevant health professionals and services can be difficult because of:

Difficulty finding local services

Lack of local services

Eligibility criteria set by local services

Out of pocket cost

Unknown waiting time to start receiving care

Inefficient methods of communication

The Medicare Benefits Schedule items for chronic disease management changed three months ago

No they didn't

Changes to the Medicare Benefits Schedule items for chronic disease management have been deferred from 1 November 2024 until 1 July 2025. The additional time will support all practices and providers, including GPs and allied health providers, to be ready for the changes to these important services.

... and software vendors – but will this be enough time, with details of the changes still not available 4.5 months before the new starting date?

https://www.health.gov.au/our-work/upcoming-changes-to-mbs-chronic-disease-management-arrangements

13 February 2025:

From 1 July 2025, Medicare Benefits Schedule (MBS) items will be changing to:

- replace the current GP Management Plan and Team Care Arrangements with a single GP Chronic Condition Management Plan

- support continuity of care by requiring patients registered for MyMedicare to access management plans through the practice where they are registered. Patients who aren't registered will be able to access management plans through their usual GP

- encourage management plan reviews by:

  - equalising the fees for developing and reviewing plans

  - requiring patients to have their plan established or reviewed in the last 18 months so they can retain access to allied health and other services

- formalise referral processes for allied health services so they are more consistent with other referral arrangements

https://www.health.gov.au/our-work/upcoming-changes-to-mbs-chronic-disease-management-arrangements

Opportunities

Implementation of FHIR and SMART on FHIR will facilitate the assembly of a current overview of the person's care

Patient enrolment in one general practice at a time will facilitate coordinated quality care

Changes to government subsidy or funding of care of people with chronic conditions might help to increase the safety, quality, efficiency and equity of care

Perspectives:

Jackie O'Connor

Nicola Mountford

Deanna Connor

(Allied Health)

Chronic Disease Management & Allied Health Professionals

Sector Summary

- Medicare funded CDM plans = 15 of 39 professions

- What information are other professions receiving?

- How do we get holistic informed care plans?

- Mandated information doesn't meet need
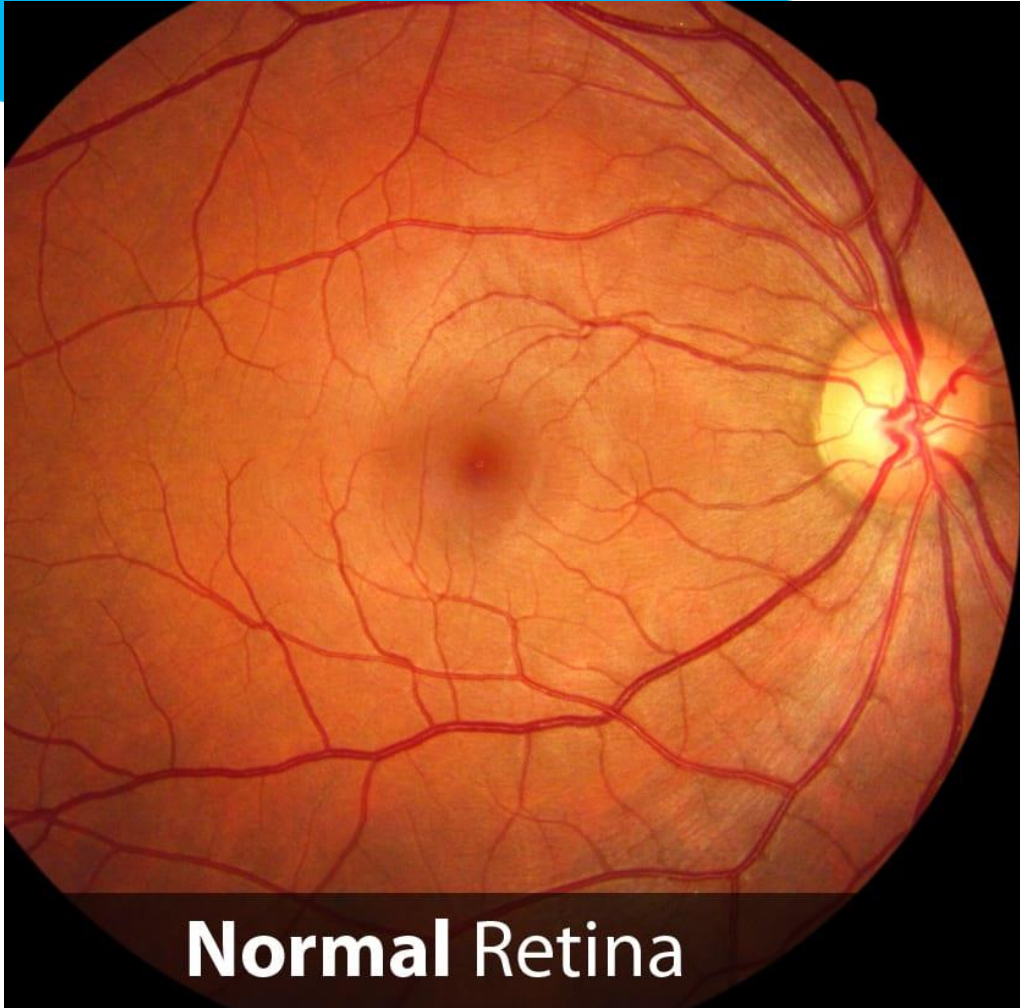
Sector Summary

- Bespoke care plans differ by
    - Profession
    - Ways of working
    - Consumer diagnoses
    - Intended audience

- Inefficiencies limit sharing beyond referrers and mandates

- It needs to be easier to share and share more.

Optometry in Chronic Disease Management

Nicola Mountford, Optometry Australia
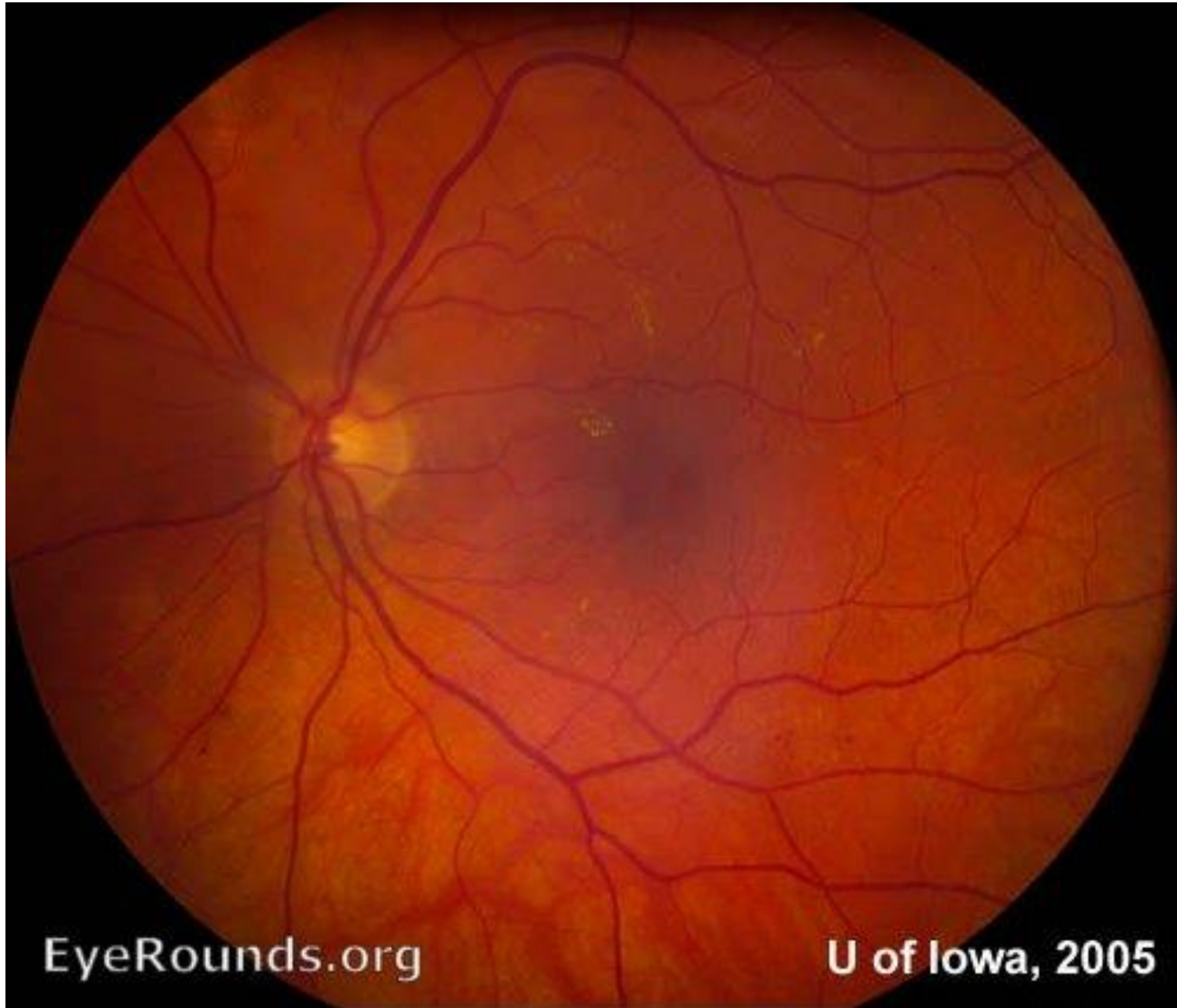
Goes far beyond refraction

Normal Retina

Diabetic Retina

https://northamptoneye.com/2019/11/diabetic-eye-disease-and-you/

https://webeye.ophth.uiowa.edu/eyeforum/atlas/pages/Diabetic-Retinopathy-non-proliferative.html

Current situation

- Patient data: age, gender, family history, ATSI status

- Patient health history: diagnoses, *year of diagnoses*

- Patient medications

Clinically empowering information

- Type and duration of diabetes

- Blood pressure

- Cholesterol/lipid status

- Glycaemic control (including HbA1C)

- Smoking status

- Renal status

- Practitioners involved in care

Our contribution

- Visual acuity

- Diagnosis/outcome and *classification*

- Examination results

- Intraocular pressures

- Advice/ outcome

n.mountford@optometry.org.au

Chronic Disease Management and Team Care Plans –
An audiologist perspective

Deanna Connor

Hearing Australia

Note: GPs can use this form issued by the Department of Health and Aged Care or one that contains all of the components of this form.

To be completed by referring GP:

Please tick:

☐ Patient has GP Management Plan (item 721) AND Team Care Arrangements (item 723) OR
☐ GP has contributed to or reviewed a multidisciplinary care plan prepared by the patient's aged care facility (item 731)

Note: GPs are encouraged to attach a copy of the relevant part of the patient's care plan to this form.

GP details

Provider Number ☐☐☐☐☐☐☐☐☐

Name _____

Address _____ Postcode

Patient details

Medicare Number ☐☐☐☐☐☐☐☐☐☐ Patient's ref no. ☐ Patient's DOB ____/____/____

First Name _____ Surname _____

Address _____ Postcode

Allied Health Provider (AHP) patient referred to: (Please specify name or type of AHP)

Name _____

Address _____ Postcode

Referral details – Please use a separate copy of the referral form for each type of service

Eligible patients may access Medicare rebates for a maximum of 5 allied health services (total) in a calendar year. Please indicate the number of services required by writing the number in the 'No. of services' column next to the relevant AHP.

No of services	AHP Type	Item Number	No of services	AHP Type	Item Number	No of services	AHP Type	Item Number
	Aboriginal Health Worker/Aboriginal and Torres Strait Islander Health Practitioner	10950		Exercise Physiologist	10953		Podiatrist	10962
	Audiologist	10952		Mental Health Worker	10956		Psychologist	10968
	Chiropractor	10964		Occupational Therapist	10958		Speech Pathologist	10970
	Diabetes Educator	10951		Osteopath	10966			
	Dietitian	10954		Physiotherapist	10960			

Referring General Practitioner's signature _____ Date signed _____

The AHP must provide a written report to the patient's GP after the first and last service, and more often if clinically necessary.

Allied health providers should retain this referral form for record keeping and Services Australia (Medicare) audit purposes.

This form may be downloaded from the Department of Health and Aged Care website.

THE FORM DOES NOT HAVE TO ACCOMPANY MEDICARE CLAIMS

Dear Hearing Australia,

Re: Team Care Arrangement

I have created a care plan for our patient Mr

Please confirm your participation by Faxing back to

Attached is a summary of a care plan for:

Mr

Phone:
Date of Birth:
Medicare No.:

Care plans can be completed for patients that have chronic and complex care needs and must involve communication and management across three health providers. Our aim is to provide our patients with improved management of their health conditions and issues.

For these reasons your input is greatly appreciated. If you have any comments to add, can you write them in the comments section at the end of the care plan summary and fax it back to us and we will incorporate them into the final care plan version. If you are happy with the plan all you need to do is fax this page back and send the feedback as per usual after you have seen the patient.

Further to this, if you are an allied health provider and registered with HIC, your patients that have already had care plans completed will be able to obtain a Medicare rebate for up to a total of five visits to allied health providers in one calendar year.

Warm regards

Faxback to

I agree to be a participating member of team care arrangements for this patient and I am registered with HIC as an Allied Health provider.

Signature.. Date....../....../..........

An audiologist perspective

What is helpful	What is not always clear to Audiologists
• Client Name and key information • GP Details • Audiological Services are required	• Appropriate funding pathway • Purpose of Referral • How do we effectively communicate with the Client • Who else is involved in the Team Care Plan • Health Conditions that may impact assessment or rehabilitation

Hearing Australia

Chronic Condition Management – Data Cycle

Information support for Chronic Conditions

- What's in the plan ?

- **'Timely'** interventions
- **Efficient** and **effective** care to optimize quality of life
- **Continuity of care**, information sharing, accessible health services and supportive systems
- **Consumers are active and empowered**

Objective 1: Prevention: National Strategic Framework for Chronic Conditions.pg17 : Australian Health Ministers' Advisory Council, 2017, National Strategic Framework for Chronic Conditions. Australian Government. Canberra).

Noncommunicable diseases progress monitor 202.Geneva: World Health Organisation;2020.Licence: CC BY-NC-SA 3.0IGO.

What is missing?

- Symptom management at home
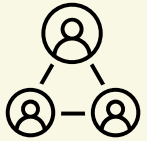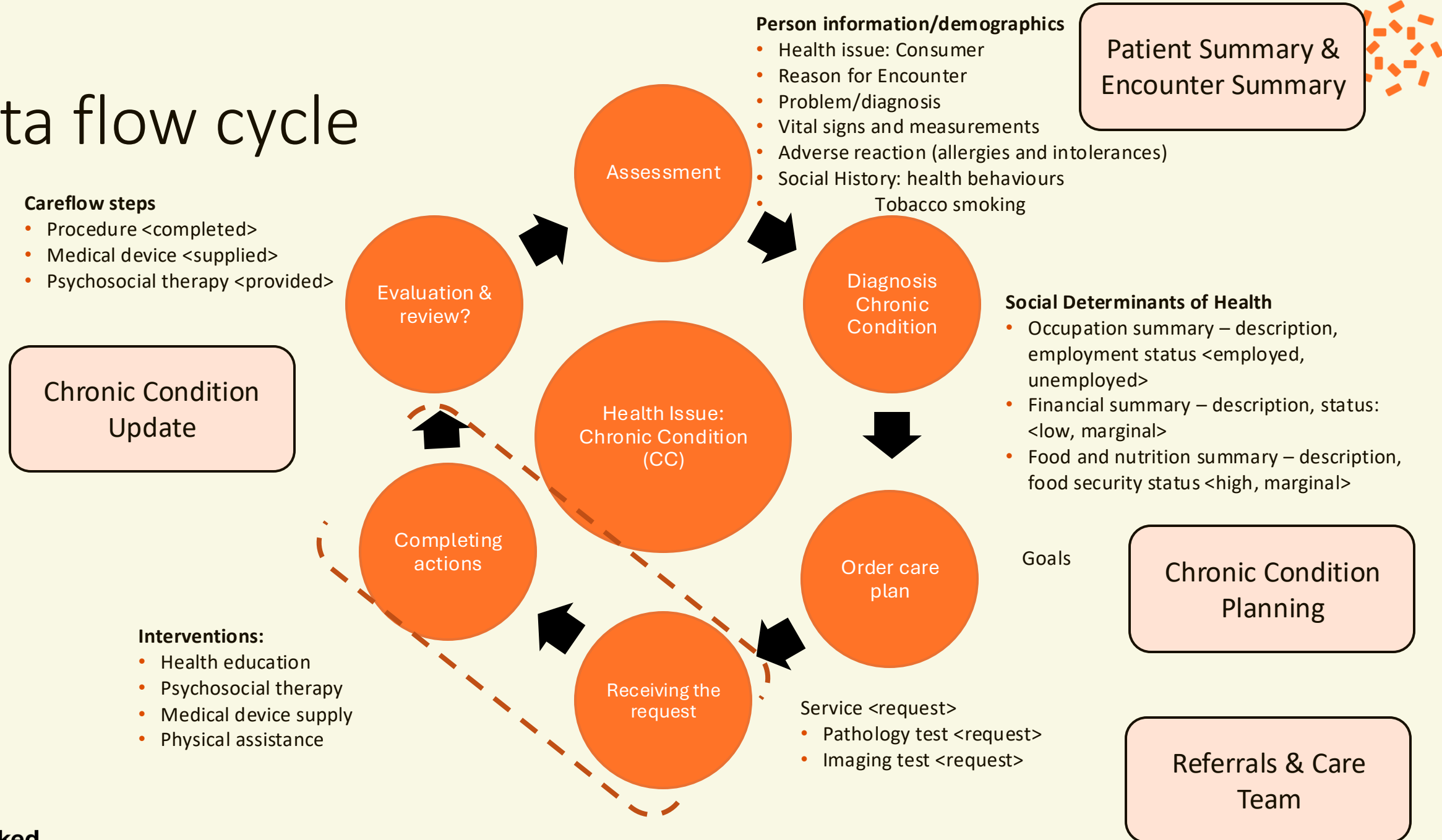
- Late presentation information
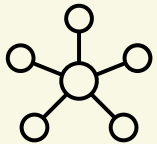
- Information is difficult to share

- Follow-up is 'challenging'…

Australian Institute of Health and Welfare (2024) Australia's health 2024: data insights, catalogue number AUS 250, AIHW, Australian Government. HTTPs://www.aihw.gov.au/reports/australias-health/chronic-conditions-challenge_accessed 6th Feb 2025

Data flow cycle

Person information/demographics
- Health issue: Consumer
- Reason for Encounter
- Problem/diagnosis
- Vital signs and measurements
- Adverse reaction (allergies and intolerances)
- Social History: health behaviours
  - Tobacco smoking

Patient Summary & Encounter Summary

Careflow steps
- Procedure <completed>
- Medical device <supplied>
- Psychosocial therapy <provided>

Chronic Condition Update

Social Determinants of Health
- Occupation summary – description, employment status <employed, unemployed>
- Financial summary – description, status: <low, marginal>
- Food and nutrition summary – description, food security status <high, marginal>

Goals

Chronic Condition Planning

Interventions:
- Health education
- Psychosocial therapy
- Medical device supply
- Physical assistance

Service <request>
- Pathology test <request>
- Imaging test <request>

Referrals & Care Team

Assessment

Evaluation & review?

Diagnosis Chronic Condition

Health Issue: Chronic Condition (CC)

Completing actions

Order care plan

Receiving the request

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Discovery- Can a Smart Form support Chronic Condition Mangement?

Chronic Condition Management Template

TCA/GP Management
Plan Template?
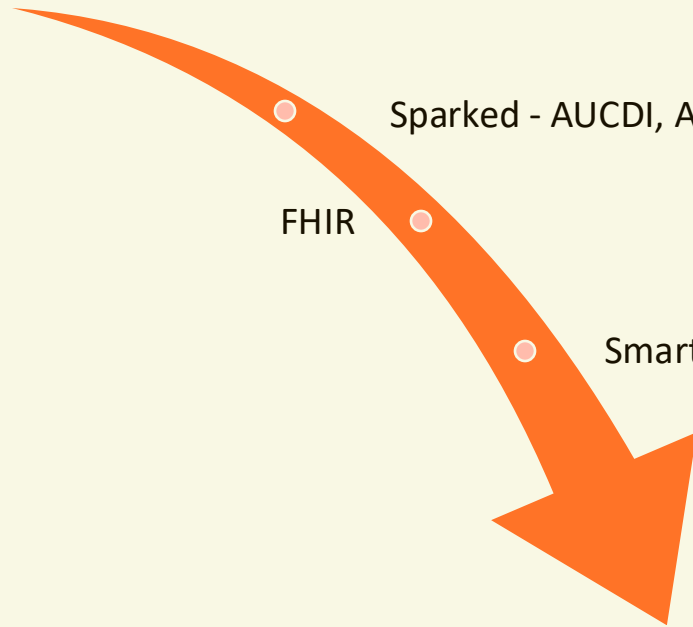
Sparked - AUCDI, AU Core

FHIR

Smart forms

Would a FHIR questionnaire template that
supports team care arrangements be useful?

Smart form Demo
Liam Barnes

Smart Forms Principles

- Forms based solution for health assessments

- Capable of integrating into existing clinical systems

- Data exchange and reuse

- Data quality improvement

- Improve efficiency for delivering clinical care

Interface

Health Service

Smart Forms Service

SMART Launch Authorisation

FHIR · Sparked

Prepopulation data

Standard data representation
Standard APIs

Write back patient data

Practice Management System

Smart Forms Services
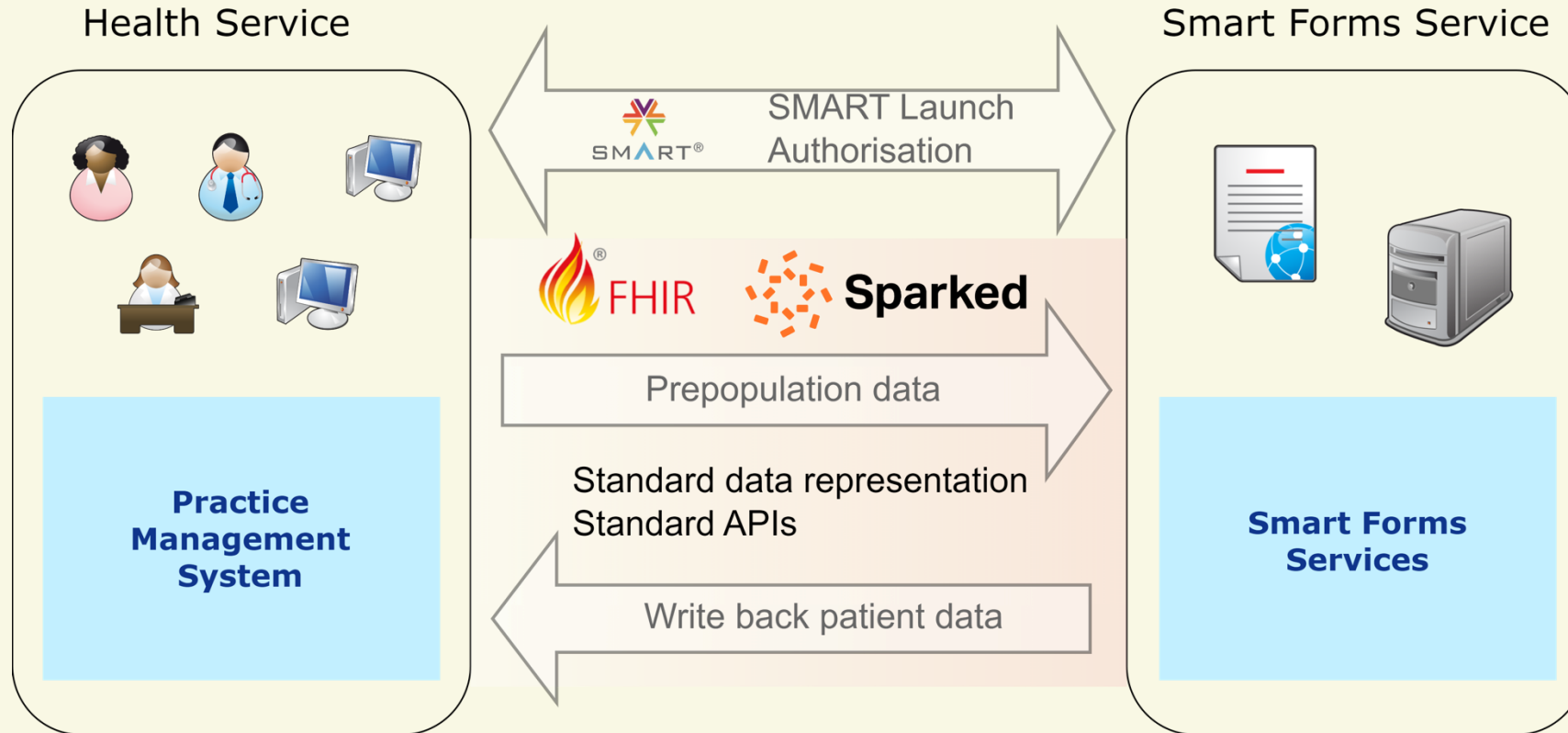
Exchange requirements

Resource interactions	First Nations Health Check Chronic Condition Management Draft Template
Read & Search	Practitioner Patient Encounter Condition Observations MedicationStatement AllergyIntolerance **AU Core** QuestionnaireResponse
Create & Update	QuestionnaireResponse **Smart Forms**

Chronic Condition Management Plans

Multiple goals could be assigned per problem

Multiple treatments/interventions or arrangements could be assigned per goal

Problem could be greyed out when resolved/inactive

Form could turn green when goal is reached

Doe, Jane
DOB 15/04/1959 (65 years)   **IHI** 8003608166690552   **Sex** Female   ⚠ **1** Adverse Reaction   🔺 **1** Alert
Provider Dr Peter Primary

Managment Plan   ADD PROBLEM   CREATE REVIEW

Problem	Goals	Treatment	Arrangements	
Type 2 diabetes mellitus	Keep foot	Refer to podiatrist	Referral sent	📝
	Lower HbA1c level	Metformin 500mg bd cc	Medication prescribed	📝
		Refer to dietitian	Referral sent	📝
Fracture of bone	Return to gardening	Set and plaster	Transport booked	📝
Hypertension	<140/90 mmHg target BP	Ramipril 5mg d	Medication prescribed	📝

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Problem Wizard Step 1 Add Problem

Could be coded and linked to pathways for common conditions (e.g. diabetes)

Doe, Jane
Provider Dr Peter Primary
DOB 15/04/1959 (65 years) **IHI** 8003608166690552 **Sex** Female ⚠ **1** Adverse Reaction 🔺 **1** Alert

Managment Plan   ADD PROBLEM   CREATE REVIEW

Problem Wizard

1 —Select Problem— 2 —Add Goals— 3 —Add Treatments— 4 —Add Arrangements

Search:

foot 🔍

diabetic foot

diabetic foot ulcer
ischaemic ulcer diabetic foot
cellulitis of foot due to diabetes mellitus
neuropathic ulcer of foot due to diabetes mellitus
infection of foot due to diabetes mellitus

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Problem Wizard Step 2 Add Goals

Problem Wizard Step 3 Add Treatment/Intervention

Problem Wizard Step 4 Add Arrangements

Workshop 1: Activity 1 – Chronic Condition Management Template (20 time)

At your table, discuss and document on the worksheet

- Key usability principles for a chronic condition management template (team care)

- Workflow challenges
  - Example – multiple contributors updating asynchronously, review and status updates, alignment of problems/goals/activities (interventions), provider directory,

- Additional information that should be recorded
  - Suggested features for future iterations
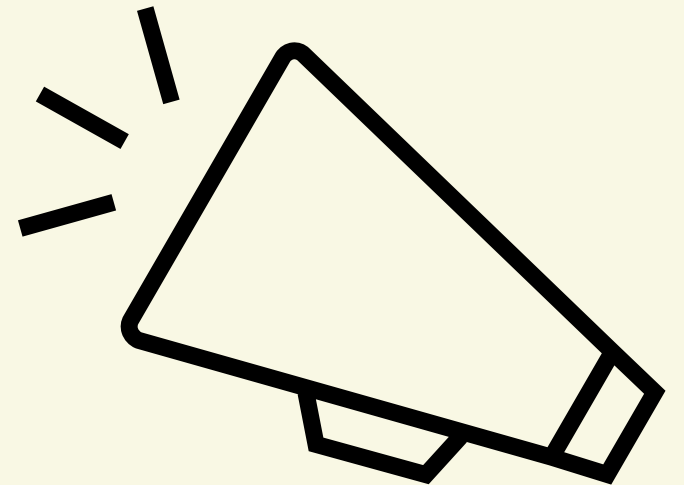
As a **group**
at your table

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Sharing time!
(10 min)

Expression of Interest
Sparked Chronic Condition Management (CCM) Clinical Focus Group

The purpose of the CCM Clinical Focus Group is to:

- Provide clinical guidance and expertise on Chronic Condition Management related user scenarios, workflows, data flows, challenges, opportunities, etc

- Creation of consumer journeys highlighting the complexities of Chronic Condition Management.

- Identifying considerations regarding the development and use of a chronic condition management template which supports team care/shared care.

- Provide clinical input and insight to relevant FHIR IGs and/or Technica Design Group(s) as required

- Support AUCDI CCM development as required

Please be aware there is a time commitment to participate in the Sparked Chronic Condition Management Clinical Focus Group (this will be a series of online workshops 1-2 hours in length)

Expression of Interest
Sparked Chronic Condition Management (CCM) Clinical Focus Group

Responses required by <u>Friday March 7th, 2025</u>

Please respond via the MS Forms link below or by using the QR code

https://forms.office.com/r/GwJsAyBgcs

EOI for Sparked AU Chronic Condition Managment (CCM) Clinical Focus Group

Back at 1:30pm

Lunch

Reason for Encounter

or is it really an

Encounter Summary

2024 CDG workshops

- Series of workshop activities focused around
  - AUCDI R2
    - Patient summary – Request for feedback <extended>
    - Chronic Condition Management
      - September, November, December, January
    - Reason for Encounter
      - September F2F, now Feb

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Reason for Encounter – Key Discussions so far

Subjective – history including patient agenda

Objective – examination, investigations

Assessment – impression or issues/problem list

Plan – management including referrals

Clinical perspective

Need more than just Reason from an Encounter

Learn from previous experiences with event summaries

Need data to demonstrate the value of care

Aide memoire

"Key considerations from the primary care provider may be informed more by the reason for encounter, rather than the primary diagnosis"

To understand complexity of care

Consumer

Understanding the journey/ interaction with health care system

Want all the information related to an encounter

AIHW

AIHW developing a data model aligning with AUCDI

Looking at a population heath point of view

Support funding and sustainability of health system

DOHAC

September 2024 – Workshop 3: Activity 1

Attendees were asked, as a group at their table, to respond to the questions detailed on the worksheet (see inset) to identify what are the common use cases for Reason for Encounter?

Including what types of reasons are recorded, and what other encounter information is available or needed?

Workshop 3: Activity 1 – Reason for Encounter (RFE) use cases
As a group, identify what are the common use cases for Reason for Encounter?
Consider what types of reasons are recorded?
What additional encounter information is available or needed?

Type of reason? E.g. Clinical, administrative, diagnostic, follow up, logistical...	Which setting? E.g. GP Clinic, ED presentation, Outpatient department, Allied health appt, ambulance...	Which systems? E.g. GP EMR, Hospital EMR, PAS, LIMS...	Whose 'reason' is it? E.g. Clinician, consumer...	Who is recording it? E.g. Clinician, consumer, administrative staff...	When is it being recorded? E.g. When booking, at Check In/on presentation, during consultation, after encounter...	Who is the information useful for? What is the value? E.g. aide memoire, chronological patient journey, information retrieval, population health...	What other related information is useful for an encounter?

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Reason for Encounter

Common use cases

Clinical Reasons

- Recording symptoms, diagnoses, and ongoing management.
- Referrals, discharge summaries, clinical history, medication review, and care plans.
- Relevant settings: GP, hospitals, clinics, aged care, and EMRs.

Consumer Reasons

- Routine check-ups, online appointments, mental health advice, and medication management.
- Involves telehealth, GP EMRs, and real-time patient engagement.

Administrative Reasons

- Handling forms, activities, routine scheduling, and financial matters.
- Includes hospital PAS, administrative procedures, and managing patient information.

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Reason for Encounter

What is the value?

Care delivery

- Aide memoire
- Understanding patient journey
- Quality improvement
- Interpretation at pathology imaging centre
- Accountability
- Clinical transfer of care
- Prioritisation/Triage of care

Research

Clinical decision support

- Can be predictive of diagnosis

Health Administrators/ Management

Funding/Billing

Population health

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Reason for Encounter

What additional information is useful?

Patient summary information

- Medical history
- Past history
- Medications

Encounter information

- How many reasons for encounter?
- Reason for activity
- Modality
- Discharge details
- Presenting problem/symptoms
- Diagnosis(SNOMED CT, ICD10, free text)
  - Principal Diagnosis
  - Diagnosis in Discharge
- Procedures
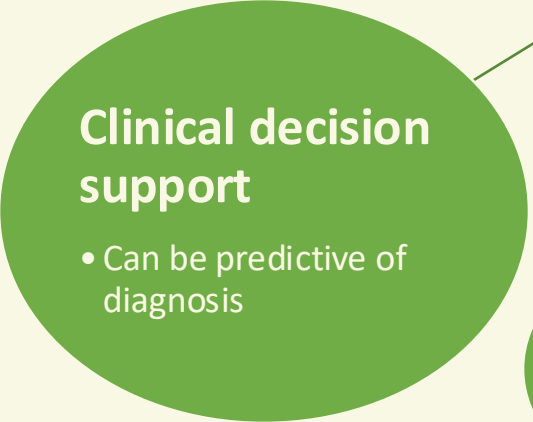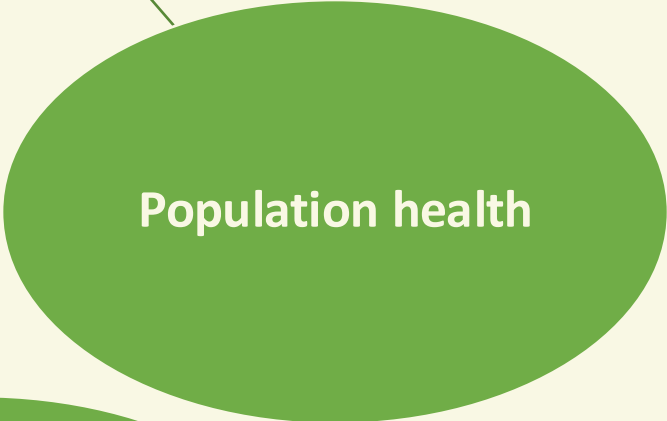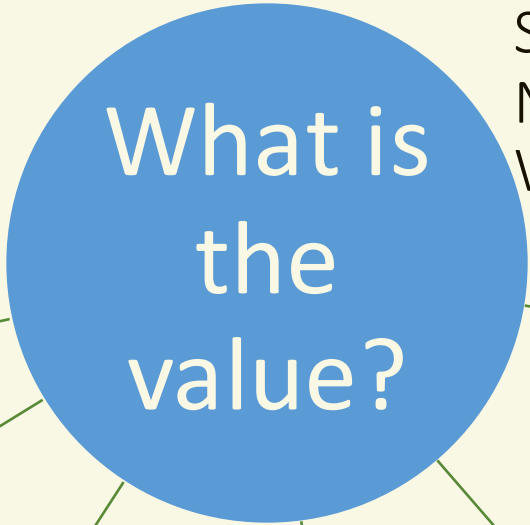
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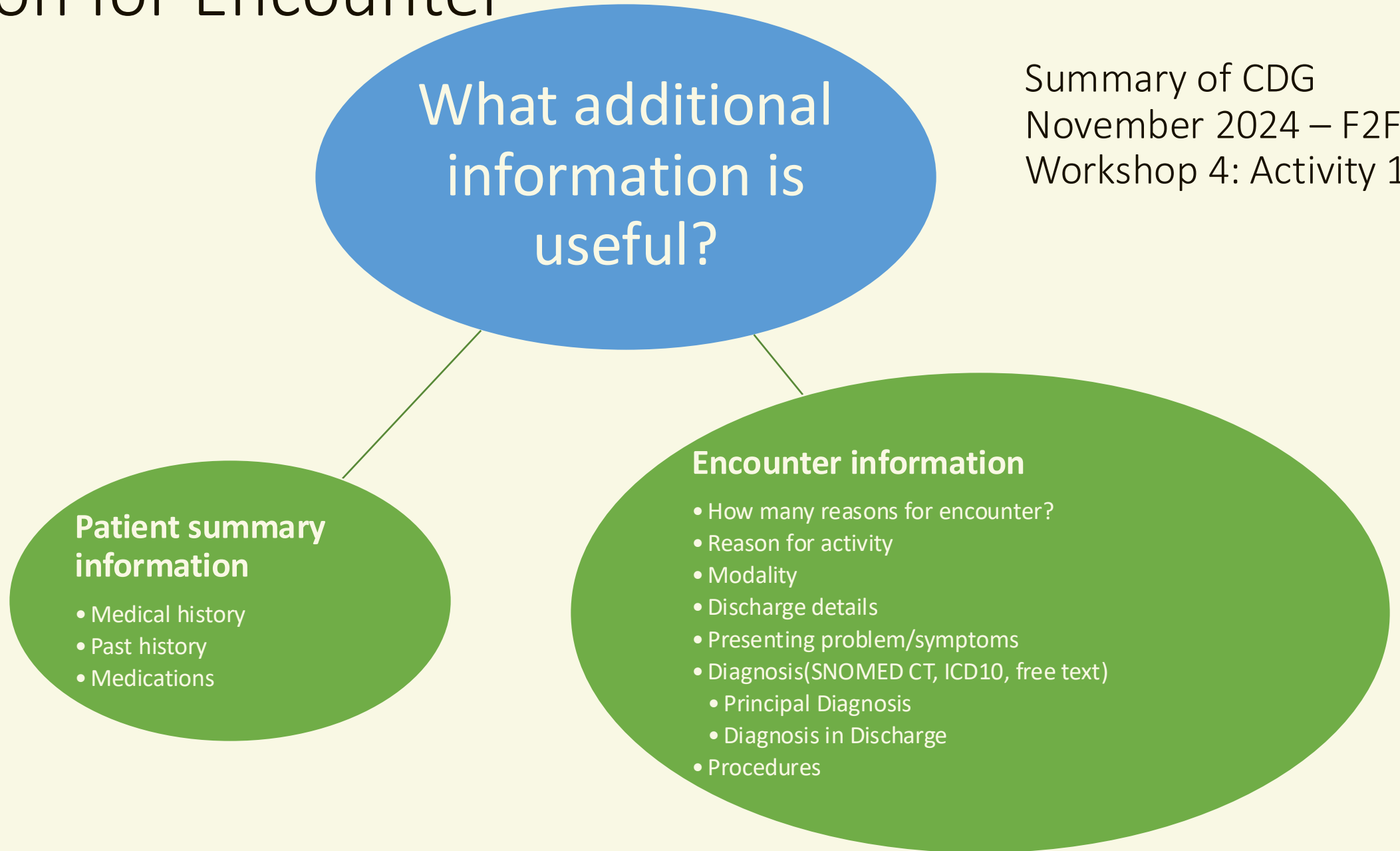
What is the value or use of Reason for Encounter information?

Need to understand what it means for whom first.	Research and analytics	Not sure	Potentially to capture the narrative for the patients visit. Especially if we only otherwise collect coded data.
Depends if it's consumer informed or clinician recorded	Clarity	Prove what has been done	Transitioning between departments - good to have a track of reasons for encounter
Linkage with problem managed	CDS	Funding advocacy	Don't know
Help me decide if I want to dig into that visit for more info	Understanding service use	Provides context to diagnosis	Analytics to support health service funding and planning
Nobody. Give reason for activity and diagnosis intead	Guiding treatment in online interactions.	eCDS	Support WHY we have provided service.
Analytics	Greater ability to manage health needs	Reimbursement	The beginning of the story

Consistency in care	Provides context to diagnosis	Additional context	Billing. Clinical decision support. Optimise "customer service" to the patient.
Patient view of why seeking vate	Triage	Provide history to the next clinician	The patient's voice
Qualitative data set for research?	Funding for activity. To identify previous events when looking back	Reason for encounter becomes useful when it provides context - maybe a resource on its own?	Learning system looking for emerging issues
To understand what is important for the patient to resolve	Clarification of different ideas patient and clinician	Monitoring progress eg. multiple presentations for UTI or tonsillitis within a particular time frame.	To record the PATIENT'S view of why they are there. Anything else is interesting but NOT reason for encounter
To stop symptoms being stated as proxy diagnoses.	Understand spectrum (or evolution) of reasons from the patient reasons to clinicians reasons and linkage to outcome	Maybe better positioned as "reason for presentation"	Context
Supporting refinement and sequencing of patient summary details	Care alignment - between patient - provider payor	Context setting - establishing and aligning the patient and care provider	Understand patient expectations and use of health services
Resource allocation. Needs to be finite sensible and succinct lists of reasons for encounter: Medical assessment, chronic disease management, meds review etc	Remove focus on generic codes for $$ to help make it more appropriate	Comprehensive view of any particular patient, clear & easily understandable	positive user outcomes

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So is it more than just a reason for encounter?

- Value in encounter information beyond **just** the reason(s) for encounter
  - Consumer reason for encounter
  - Clinician reason for encounter
  - Investigations
  - Provisional diagnosis
  - Relevant results
  - Recommended treatment plan
  - Follow-ups
  - …
  - …
- A summary of the things that happened in an encounter?

Could these be considered Encounter Summaries?

- Hospital discharge summaries (patient summary PLUS encounter information ?)

- Event summary (MyHR)

- Progress notes/Consultation notes (in local CIS, EMR)

- Consult letter from specialist, allied health back to a usual healthcare provider or GP

- Transition/transfer of care documentation

- Etc

- Etc

National Guidelines for On-Screen Presentation of Discharge Summaries (ACSQHC 2017)	RACGP Criterion-c7-1 Content of patient health records
Patient details	Patient details
Facility details	
Recipients	
Authors	
Encounter details (date, length of encounter, location, episode type…)	Encounter details (Date of consultation, who conducted the consultation, method of communication)
Problems and diagnoses	
Principal diagnosis	Diagnosis (if appropriate)
Reason for presentation	Reason for encounter
Secondary diagnoses	
Complications	
Past medical history	Relevant past medical history
Procedures	Examinations and investigations in the encounter
Clinical summary	
Adverse reaction risk (Allergies/Intolerances)	Adverse reaction risk (Allergies/Intolerances)
Medication statement	Medication requests from the encounter
Ceased medications	
Alerts	
Recommendations	Recommended management plan and review (if appropriate)
Follow up	Referrals
Information provided to patient	
Selected investigation results	

Purpose of AU Patient summary - v0.5

A Patient Summary is a standardised collection of an individual's health and healthcare information. Rather than an entire health record, it is the minimum sufficient data to support facilitation of safe, quality and efficient care.

The AU Patient Summary will support the consumer on their healthcare journey providing the consumer and their healthcare providers with timely and current access to relevant health information. It will enable individuals to share their healthcare information when travelling (including internationally).

Characteristics of AU Patient Summary – v0.5

The AU Patient Summary will:

- Be an interoperable set of clinical data.

- Will contain as up to date information as possible based on available sources at a point in time.

- May be either an asserted or non-asserted patient summary

- May include asserted and non-asserted information.

- Will be portable and accessible to the individual and their healthcare providers.

- Will support individuals on their healthcare journey.

- Will support all transitions of care.

- Will be conformant to the International Patient Summary Standard.

Patient Summary vs Encounter Summary

	Patient Summary	Encounter Summary
Clinical summary		
Reason for encounter/presentation		Reasons for encounter/presentation
Follow-ups. referrals		Follow-ups, service requests and referrals from the encounter
Encounter details (date, location, modality...)		Encounter details
Problem/Diagnosis	Summary of all (active and inactive)	Principle and additional diagnosis of the encounter, Provisional diagnosis of the encounter, ..
Procedures/Interventions	Summary of completed	Procedures and interventions scheduled or completed during the encounter (includes information provided to patient)
Vaccination administered	Summary of all	Administered during the encounter
Adverse reaction risk summary	**Summary of all**	**Summary of all?? Newly identified??**
Medication use	Current meds list (including both active and inactive)	Changes to medications (new and ceased) from the encounter
Test results	Summary of all	Test orders and results associated with the encounter
Vital signs and measurements	Summary of all	Measurements from the encounter
Plan of care	Management plans	Management plan developed in or used for encounter
Assessments and scores	Summary of all	Performed during the encounter
Alerts	**All**	**All? Newly added??**

Panel

Charlotte Hespe   Chris Moy   Vicki Bennett   Marc Belej   Jeremy Sullivan
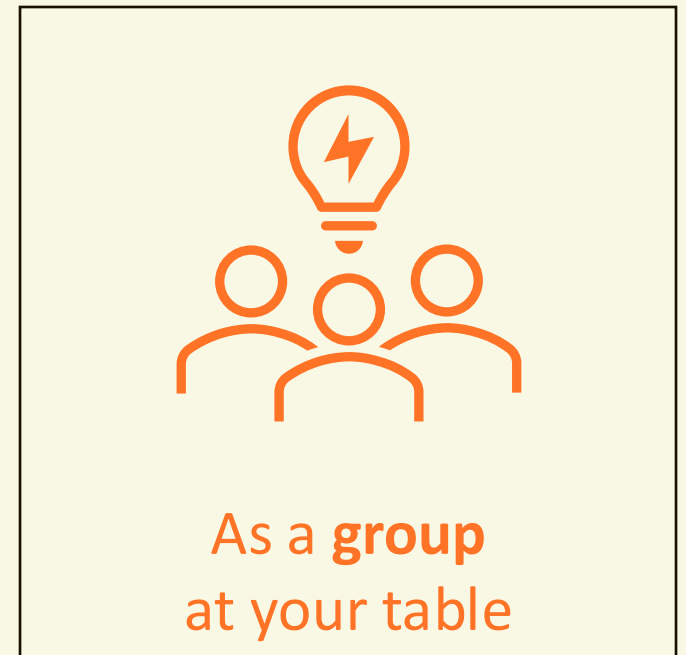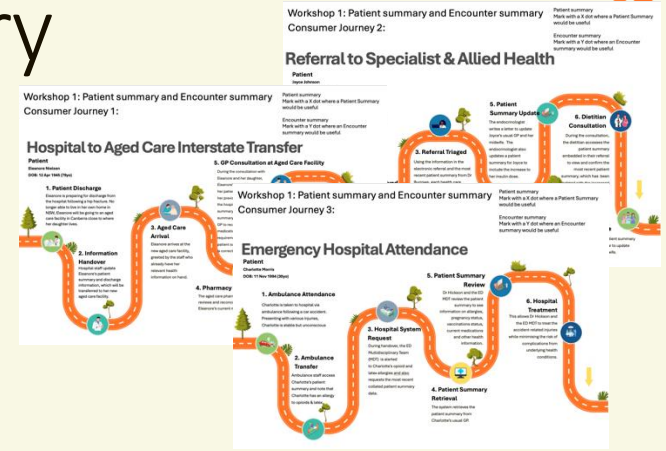
What is an Encounter Summary?

- Is it an encounter focused summary with specific details including
  - Encounter details
    - Date of encounter
    - Length of encounter
    - Who conducted the encounter
    - Method of communication
    - Location of encounter
  - Reasons for encounter
    - Clinician reason
    - Consumer reason
    - Administrative reason
  - Problem/diagnosis
    - Principle and additional diagnoses
    - Working/Suspected

Workshop 2: Activity 1 – Encounter Summary (10 minutes)

- As a group at your table, for each of the THREE consumer journey diagrams, discuss and agree at which points in the journey an encounter summary would be useful (including current use)

  - Mark with a GREEN dot where an Encounter summary would be useful

  - Add an ORANGE dot where the Encounter summary could be used to update an auto- generated Patient Summary

As a **group**
at your table

Have a hairy question? Please
note on a post it note!

Care to Share!
(5 min)

- One representative from each table to transfer the information to the consumer journeys on the wall
  - Mark with a GREEN dot where an Encounter summary would be useful
  - Add an ORANGE dot where the Encounter summary could be used to update an auto- generated Patient Summary

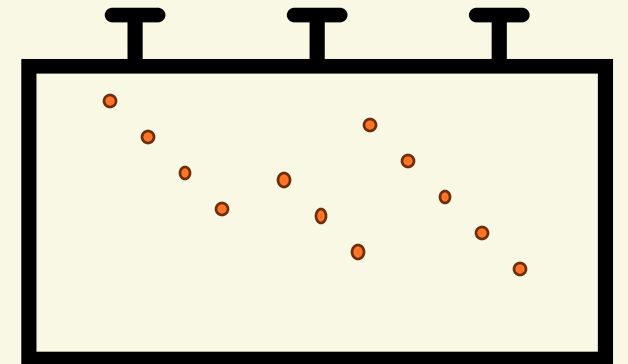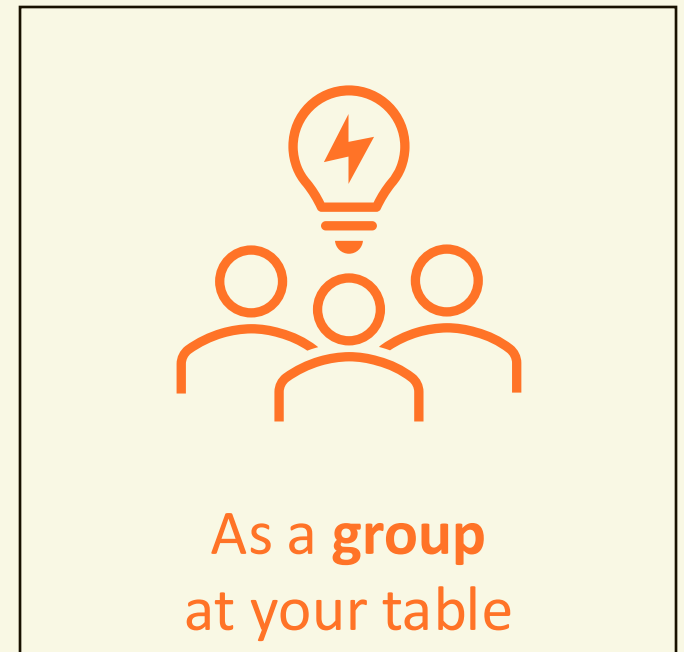Have a hairy question? Please note on a post it note!

Workshop 2: Activity 2 – Encounter Summary (20 minutes)

What data should be prioritised for an Encounter Summary?

- In your group, complete the worksheet at your table

- Consider the following:
    - What data should be included in an encounter summary in each of these settings?
    - What data should NOT be included in an encounter summary?
    - Additional data we haven't considered
    - Additional settings we should think about

- As a table, agree what are the top 5 data groups that represents the priority information from an encounter that should be structured and coded to ensure it can flow into a generated patient summary

Have a hairy question? Please note on a post it note!

As a **group** at your table

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Workshop 2: Activity 2 – Encounter Summary (20 minutes)

- What data should be prioritised for an Encounter Summary?
  - Mark a TICK in the box of data that should be included in the encounter
  - Mark a CROSS in the box of data that should NOT be included in an encounter summary
  - Add missing data groups to the empty rows
  - Use the second sheet for any additional settings
- **Mark the top 5 data groups** that represent the priority information from an encounter that should be structured and coded to ensure it can flow into a generated patient summary

Have a hairy question?
Please note on a post it note!

Add missing data groups to the empty

| Data groups	Acute care discharge summary	GP Enc sun
Clinical summary	✗	
Reason for encounter/presentation	✓	
Follow-ups. referrals	✓	
Encounter details (date, location, modality...)		
Problem/Diagnosis		
Procedures/Interventions		

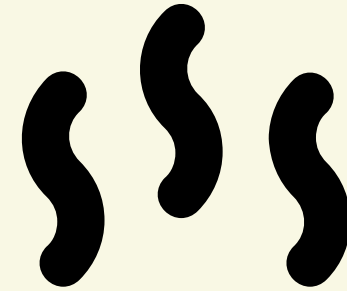**Sparked**
HL7 FHIR

Care to Share!
(10 min)

- One representative from each table to transfer the information to the tables on the wall
  - Mark the ticks with an ORANGE dot
  - Mark the crosses with a BLACK dot
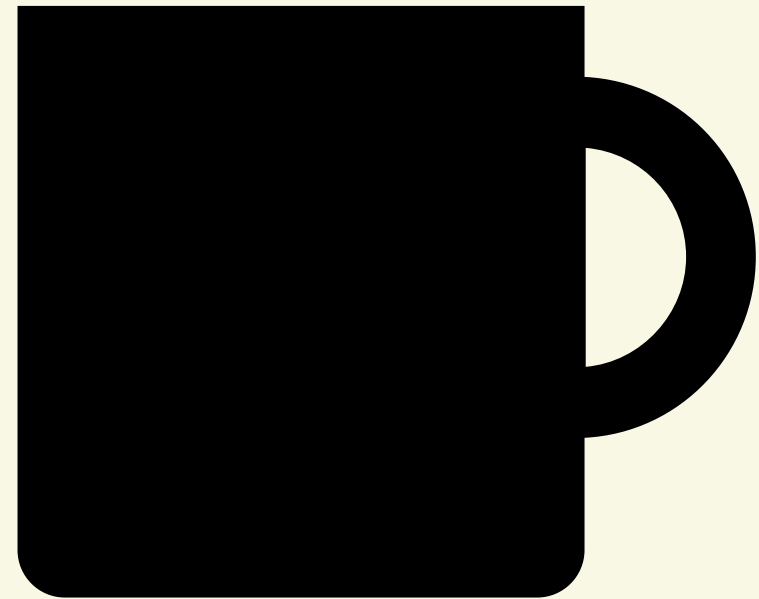 - Mark the top 5 with a GOLD dot

Have a hairy question? Please note on a post it note!
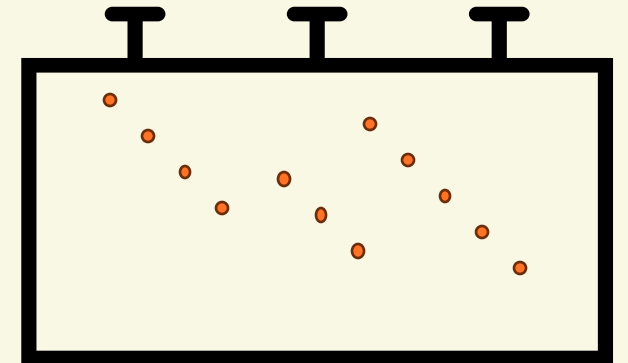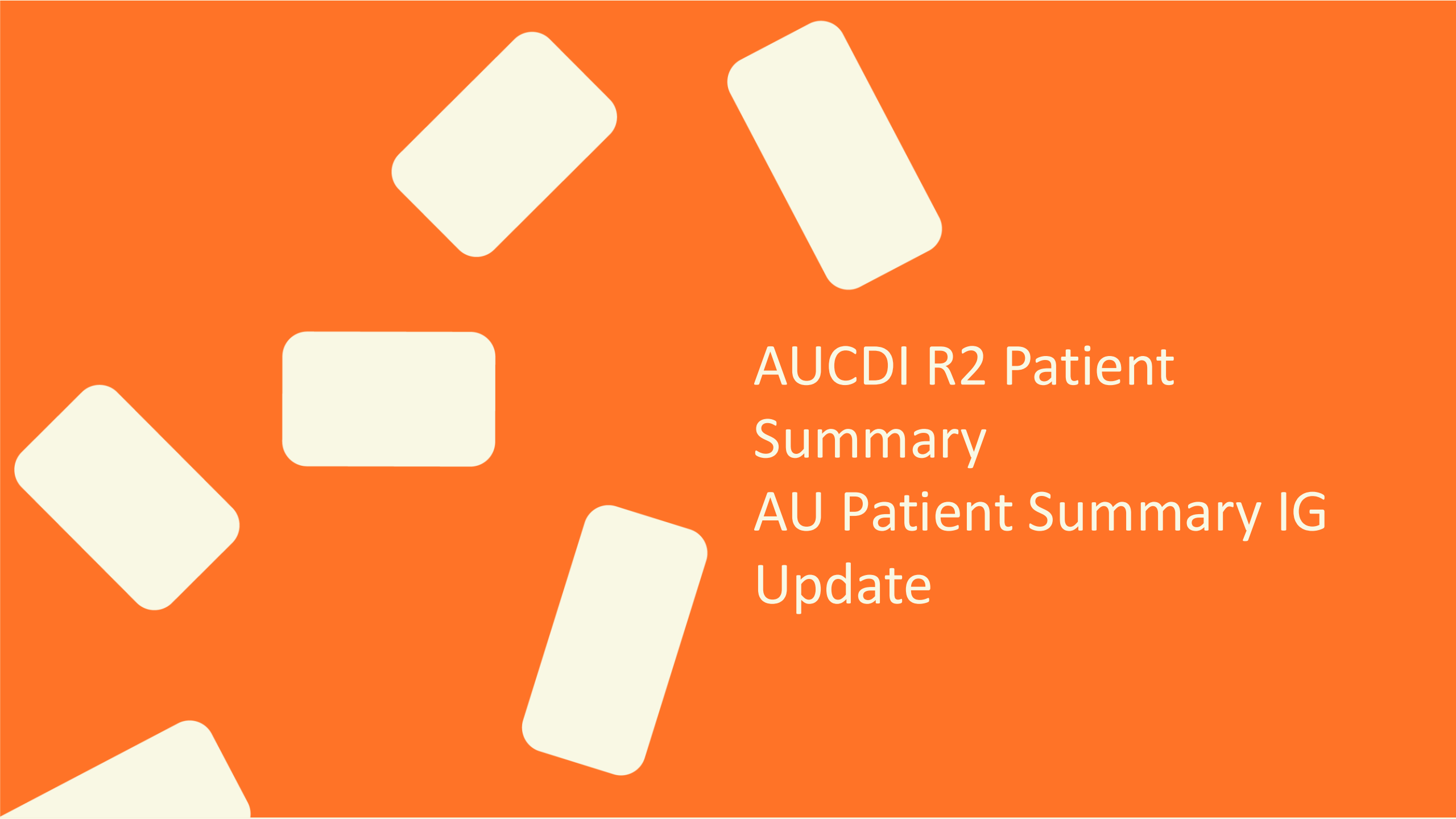
Back at 3:30pm

Afternoon tea

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Patient Summary
Patient Story

AUCDI R2 Patient Summary
AU Patient Summary IG Update

AUCDI Release 2 – Patient Summary

Problem/Diagnosis
- Problem/diagnosis name
- Body site/laterality
- Date/time of onset
- Date/time of resolution
- Status
- Comment
- Last updated

Adverse reaction risk summary
- Substance name
- Date/time of onset of first reaction
- Manifestation/s
- Severity of reaction
- Comment
- Last updated

Sex and Gender Summary
- Sex assigned at birth
- Gender identity
- Pronouns
- Last updated

Pregnancy assertion
- Pregnancy assertion
- Justification
- Date of assertion

Procedure completed
- Procedure name
- Body site/laterality
- Clinical indication
- Date performed
- Comment

Medication use statement
- Medication name
- Form
- Strength
- Route of administration
- Dose amount and timing
- Clinical indication
- Comment
- Date of assertion

Last Menstrual Period assertion
- Date of onset
- Certainty
- Date of assertion

Estimated date of delivery summary
- EDD by cycle
- EDD by ultrasound
  - Date of ultrasound
  - Gestation by scan
- Last update

Vaccination administered event
- Vaccine name
- Sequence number
- Date of Administration
- Comment

Draft for community comment completed
Working through feedback now

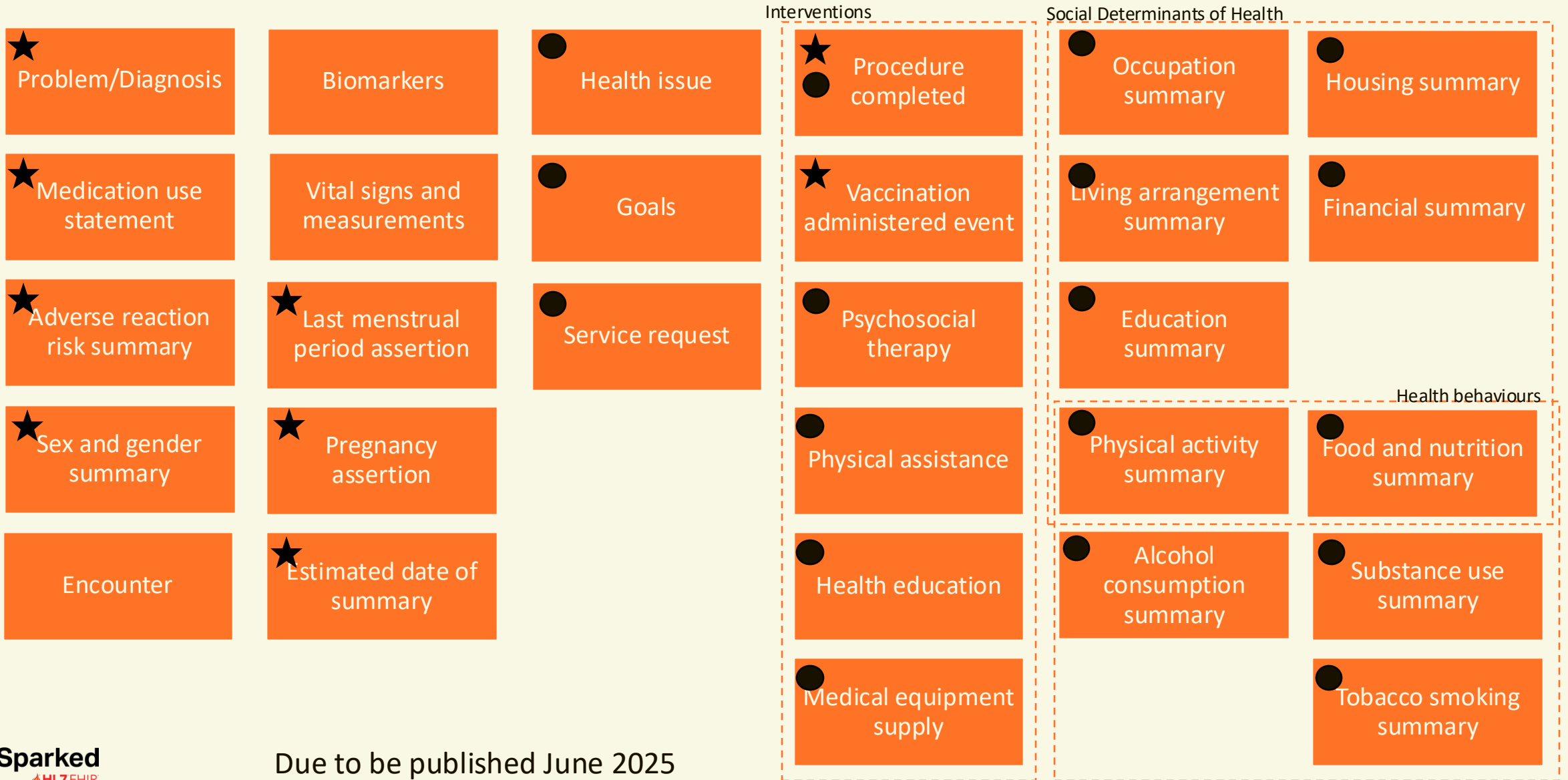New content for AUCDI Release 2 are noted in black text

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Patient Summary Clinical Focus Group update

- 5 Patient Summary Consumer Journey maps developed
  - Interstate GP Visit
  - Emergency Hospital Attendance
  - Referral to Specialist & Allied Health
  - Hospital to Aged Care Interstate Transfer
  - Pre-operative Surgical Journey
- Unbound by system limitations
- Illustrate the interactions and use of a patient summary during a consumer's healthcare journey
- Are being used by the AU Patient Summary FHIR IG project

Scope of AUCDI Release 2

★ Patient summary

● Chronic condition management (proposed)

★ **Problem/Diagnosis**

Biomarkers

● **Health issue**

★ ● **Procedure completed**

● **Occupation summary**

● **Housing summary**

★ **Medication use statement**

Vital signs and measurements

● **Goals**

★ **Vaccination administered event**

● **Living arrangement summary**

● **Financial summary**

★ **Adverse reaction risk summary**

★ **Last menstrual period assertion**

● **Service request**

● **Psychosocial therapy**

● **Education summary**

★ **Sex and gender summary**

★ **Pregnancy assertion**

● **Physical assistance**

● **Physical activity summary**

● **Food and nutrition summary**

Encounter

★ **Estimated date of summary**

● **Health education**

● **Alcohol consumption summary**

● **Substance use summary**

● **Medical equipment supply**

● **Tobacco smoking summary**

Interventions

Social Determinants of Health

Health behaviours

Due to be published June 2025

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December 2024 **TDG** scoping workshops

- Series of workshop activities focused around the FHIR IGs:
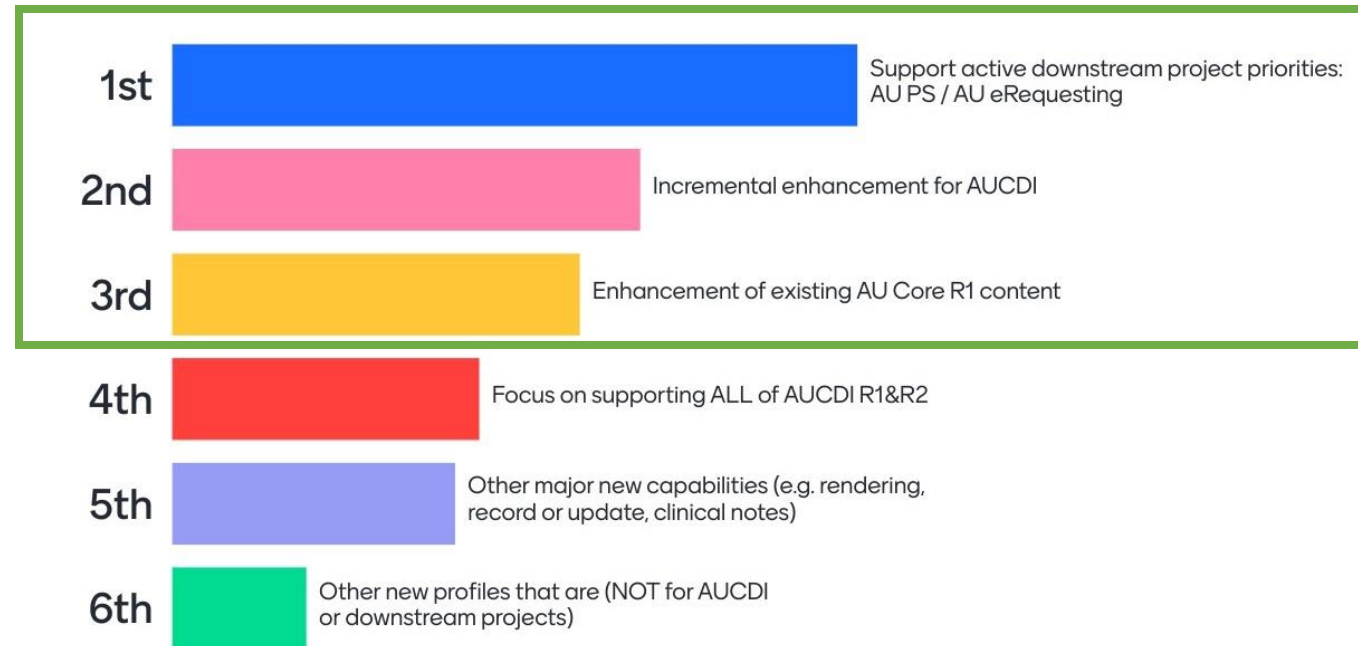 - AU Core R2
  - AU Patient Summary R1

Quick Recap: Focus for AU Core R2

1. Support AU PS & AU eRequesting priorities

2. Incremental enhancement of AUCDI coverage

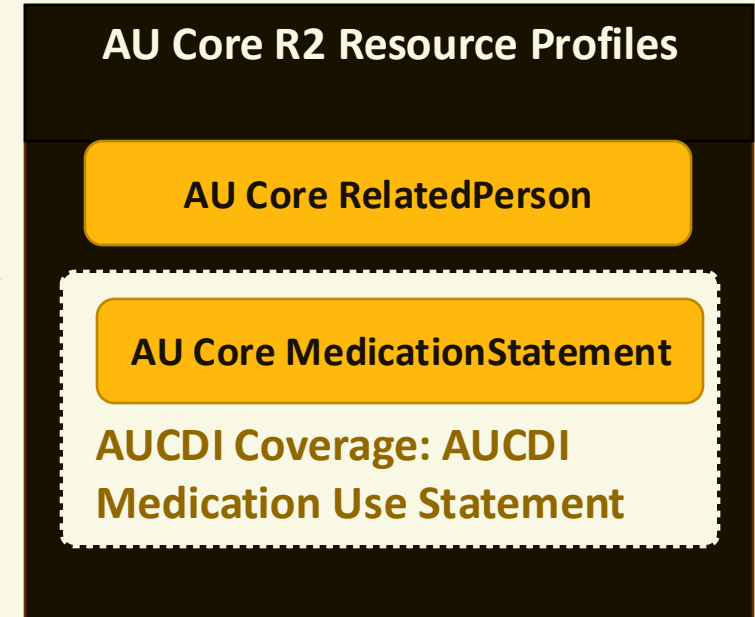3. Enhancement of existing AU Core R1 content

What should the focus of AU Core R2 should be?

Rank	Focus
1st	Support active downstream project priorities: AU PS / AU eRequesting
2nd	Incremental enhancement for AUCDI
3rd	Enhancement of existing AU Core R1 content
4th	Focus on supporting ALL of AUCDI R1&R2
5th	Other major new capabilities (e.g. rendering, record or update, clinical notes)
6th	Other new profiles that are (NOT for AUCDI or downstream projects)

Quick Recap: AU Core R2 Scoping workshop outcomes

- New profiles:
  - AU Core RelatedPerson – supporting AU Patient Summary
  - AU Core MedicationStatement – supporting AU Patient Summary
- AUCDI coverage enhancement
  - Medication Use Statement
- Enhancement of existing content
  - To come through proposals / spec feedback
- Overall, AU Core Backlog validated – broad range of items are of interest
  - https://confluence.hl7.org/display/HAFWG/AU+Core+Backlog
  - https://confluence.hl7.org/display/HAFWG/AU+Core+Parking+Lot+of+Discussion+Topics+and+Ideas

AU Core R2 Resource Profiles

AU Core RelatedPerson

AU Core MedicationStatement

AUCDI Coverage: AUCDI Medication Use Statement

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AU Core R2 at a glance

R1 CapabilityStatements

- **AU Core Responder**
- **AU Core Requester**

R1 ActorDefinitions

- **AU Core Responder**
- **AU Core Requester**

R1 Resource Profiles

- **Heart Rate**
- **Smoking Status**
- **Practitioner**
- **Respiration Rate**
- **Immunization**
- **Condition**
- **Body Weight**
- **Blood Pressure**
- **PractitionerRole**
- **Body Temperature**
- **Body Height**
- **Location**
- **Diagnostic Result Observations**
- **Pathology Result Observations**
- **Procedure**
- **MedicationRequest**
- **Encounter**
- **Organization**
- **AllergyIntolerance**
- **Patient**
- **Medication**
- **Waist Circumference**

R2 Resource Profiles

- **MedicationStatement**

  AUCDI Coverage: AUCDI Medication Use Statement

AU Core R2 (AU Patient Summary R1 | AU eRequesting R1)

- **Related Person**

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Quick Recap: AU PS R1 FHIR

Outcome	Meeting
AU Patient Summary to be compliant with IPS and AU Core	15 November 2024
Target dependencies for AU PS R1: FHIR R4, IPS 2.0.0, AU Core R2, AU Base R5	29 November 2024
Consumer journeys & technical use cases we should focus on in AU PS R1	29 November 2024

Mentimeter

Which consumer journeys should we focus on for AU Patient Summary in R1?

- 1st — Emergency Hospital Attendance
- 2nd — Interstate GP Visit
- 3rd — Referral to Specialist & Allied Health
- 4th — Hospital to Aged Care Interstate Transfer
- 5th — Pre-operative Surgical
- 6th — Something else

Mentimeter
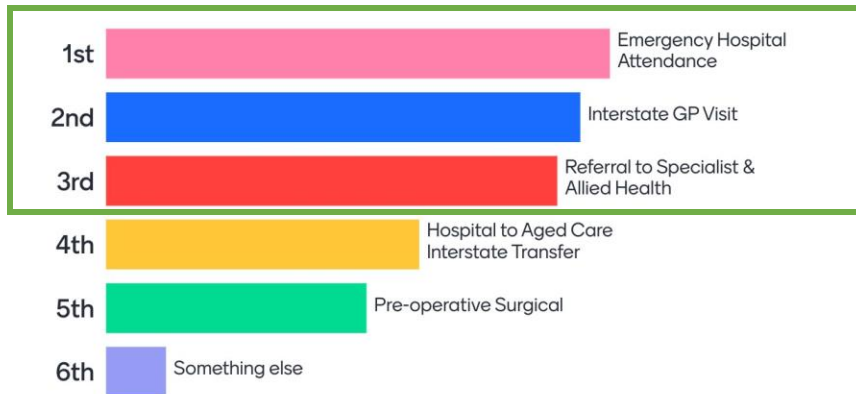
Which technical use case fit your Patient Summary use case?

- 31 — Patient Driven Patient Summary
- 28 — Clinician Driven Patient Summary
- 18 — Clinician Driven Patient Summary (as Supplemental Information)
- 1 — Something else

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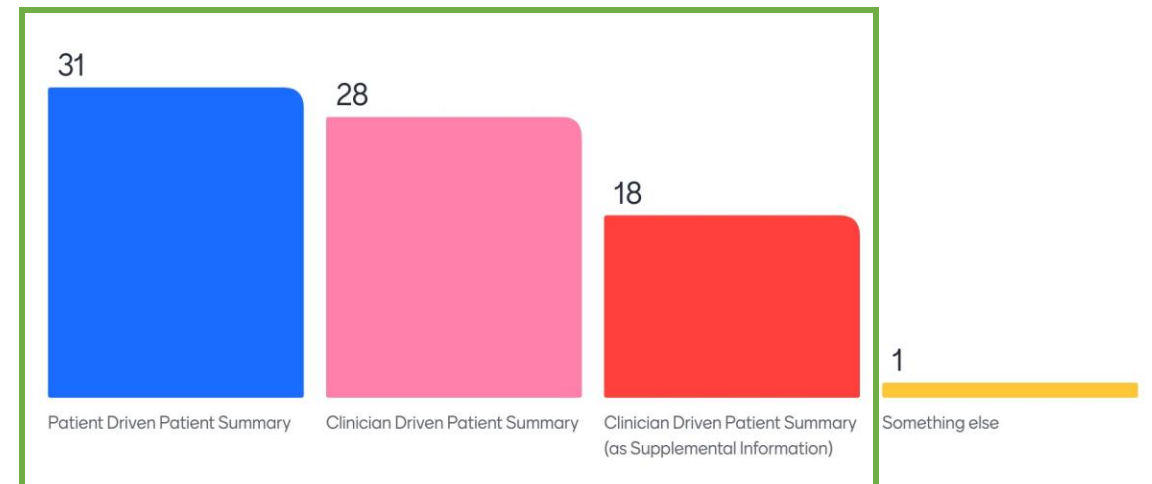
AU PS R1 – prioritised technical use case features

1.Generation: relates to the expectations of a system to have the capability to have a patient summary with the defined content. In stds space this might be operations, parameters or other attributes relating to generating a patient summary.

2.View: the expectation that a patient can present a human readable view of a Patient Summary.

3.Retrieve latest: Patient Summary can be generated in a number of systems, and there is a need to be able to identify the latest, e.g. to make sure a clinician can retrieve the latest / most clinically relevant Patient Summary from a GP. Some summaries may be focused, some federated, and some wholistic (usually from the patient's regular GP). Highlighted the importance of the provenance of IPS. For R1, the focus will need to be on access from a single system, with the view that later it may be retrieved from any system.

What use case features should be supported in AU PS R1?

Rank	Feature
1st	generation
2nd	view
3rd	retrieve latest
4th	retrieve at point in time
5th	discovery (patient summary, practice, patient)
6th	privacy, redaction and access policy
7th	authorisation
8th	trusted source
9th	generate QR code/link
10th	customised content/different types
11th	narrative
12th	update a ps

AU Patient Summary Data Group Prioritisation

Agreed top priority for patient summary

FHIR AU Patient Summary **R1** Priority Scope

CDG Patient Summary Priority Scope
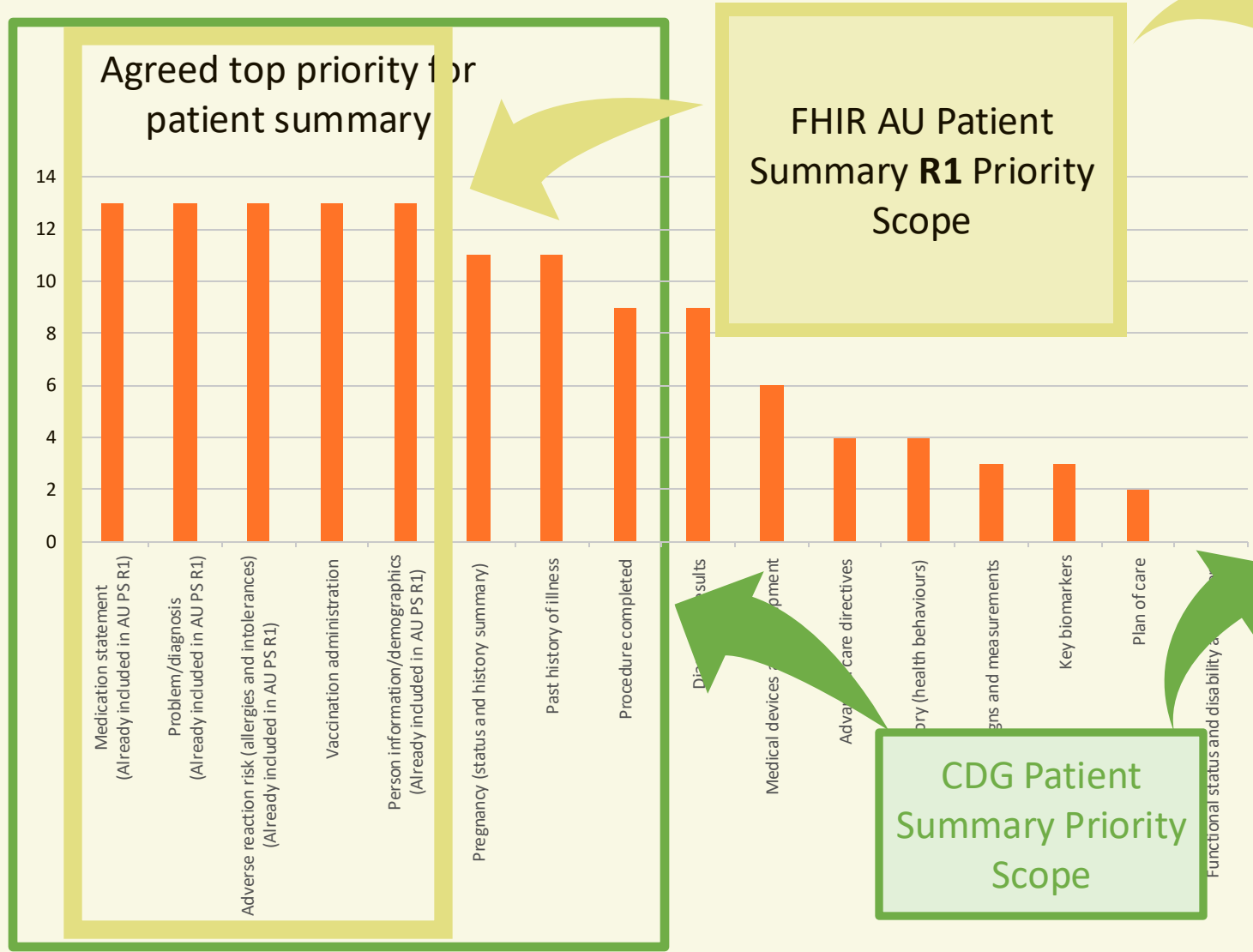
	Data group	AU PS reqd	AUCDI R1
1	Medication statement	✔	✔
2	Problem/diagnosis	✔	✔
3	Adverse reaction risk (allergies and intolerances)	✔	✔
4	Vaccination administration		✔
5	Person information/demographics	✔	✔
6	Pregnancy (status and history summary)		
7	Past history of illness		?
8	Procedure completed		✔
9	Diagnostic results		
10	Medical devices and equipment		?
11	Advance care directives		
12	Social History (health behaviours)		?
13	Vital signs and measurements		
14	Key biomarkers		✔
15	Plan of care		
16	Functional status and disability assessment		

Diagnostic results to be deferred to TDG discussions

AUCDI Release 2 – Patient Summary

Problem/Diagnosis
- Problem/diagnosis name
- Body site/laterality
- Date/time of onset
- Date/time of resolution
- Status
- Comment
- Last updated

Adverse reaction risk summary
- Substance name
- Date/time of onset of first reaction
- Manifestation/s
- Severity of reaction
- Comment
- Last updated

Sex and Gender Summary
- Sex assigned at birth
- Gender identity
- Pronouns
- Last updated

Pregnancy assertion
- Pregnancy assertion
- Justification
- Date of assertion

Procedure completed
- Procedure name
- Body site/laterality
- Clinical indication
- Date performed
- Comment

Medication use statement
- Medication name
- Form
- Strength
- Route of administration
- Dose amount and timing
- Clinical indication
- Comment
- Date of assertion

Last Menstrual Period assertion
- Date of onset
- Certainty
- Date of assertion

Estimated date of delivery summary
- EDD by cycle
- EDD by ultrasound
  - Date of ultrasound
  - Gestation by scan
- Last update

Vaccination administered event
- Vaccine name
- Sequence number
- Date of Administration
- Comment

AU PS

Focus of R1 – localisation (understanding of AU requirements)

Potential R2

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Focus of AU Patient Summary FHIR IG R1

The IPS Composition

AU PS

✓ To be localised in R1

PAMPI
P – Problems
A – Allergies
M – Medications
P – Procedures
I – Immunizations
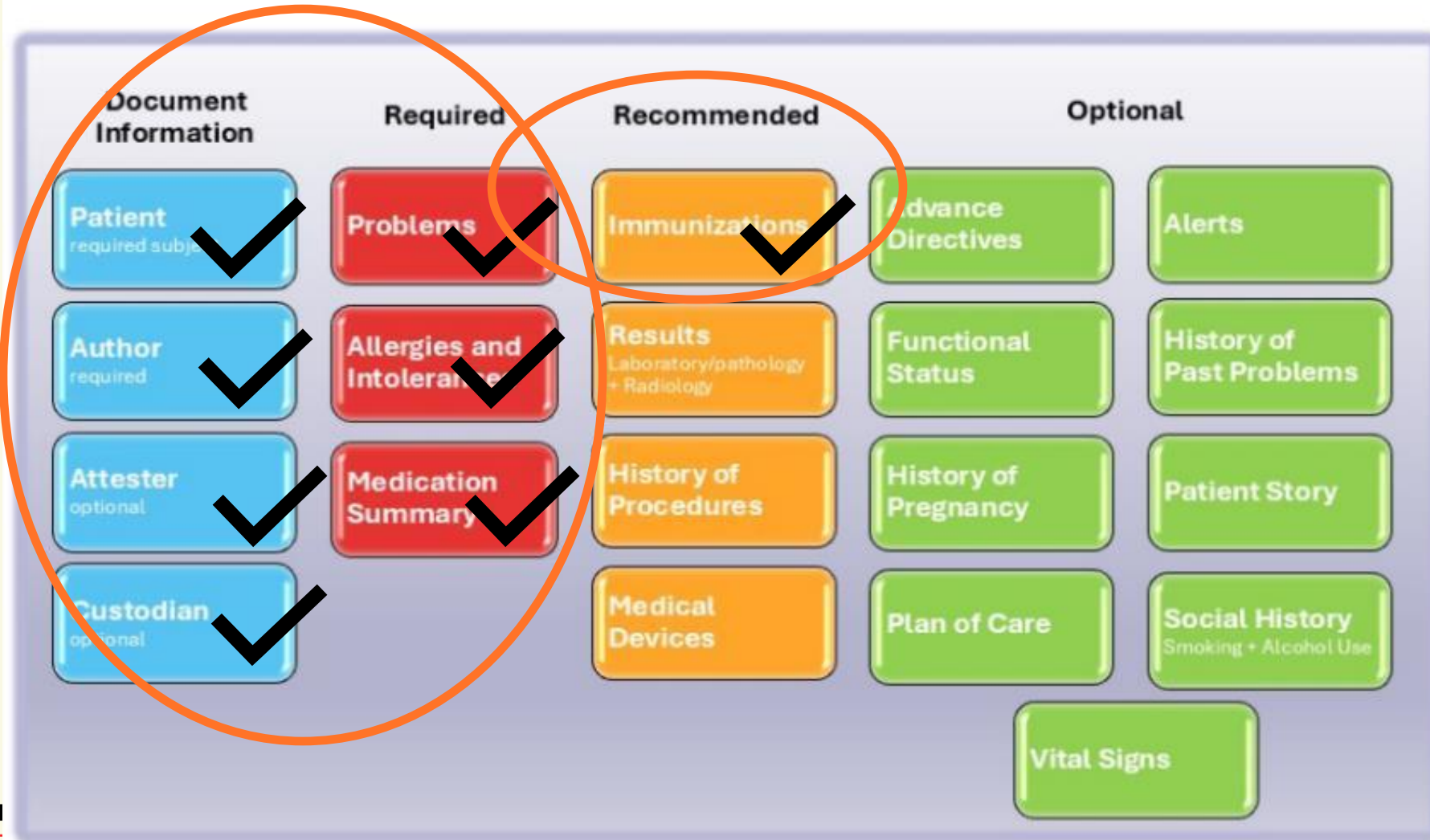
AU Patient Summary FHIR IG R1 Focus

- Working through what it means to generate (author) and view patient summaries in an Australian healthcare context in the following cases:
  - Interstate GP Visit – Patient Driven use case
  - Emergency Hospital Admission – Clinician Driven Patient Summary use case
  - Referral to Specialist and Allied Health - Clinician Driven Patient Summary (as Supplemental Information) use case
- Working through localising patient and provider demographics, document context, problems, allergies, **medications**, and immunisations (vaccination).

IPS

feeds into   complies with

AUCDI   feeds into   AU Core   feeds into   AU Patient Summary
         implements   complies with

AU Patient Summary FHIR IG: Computable form of consensus for patient summaries in Australia

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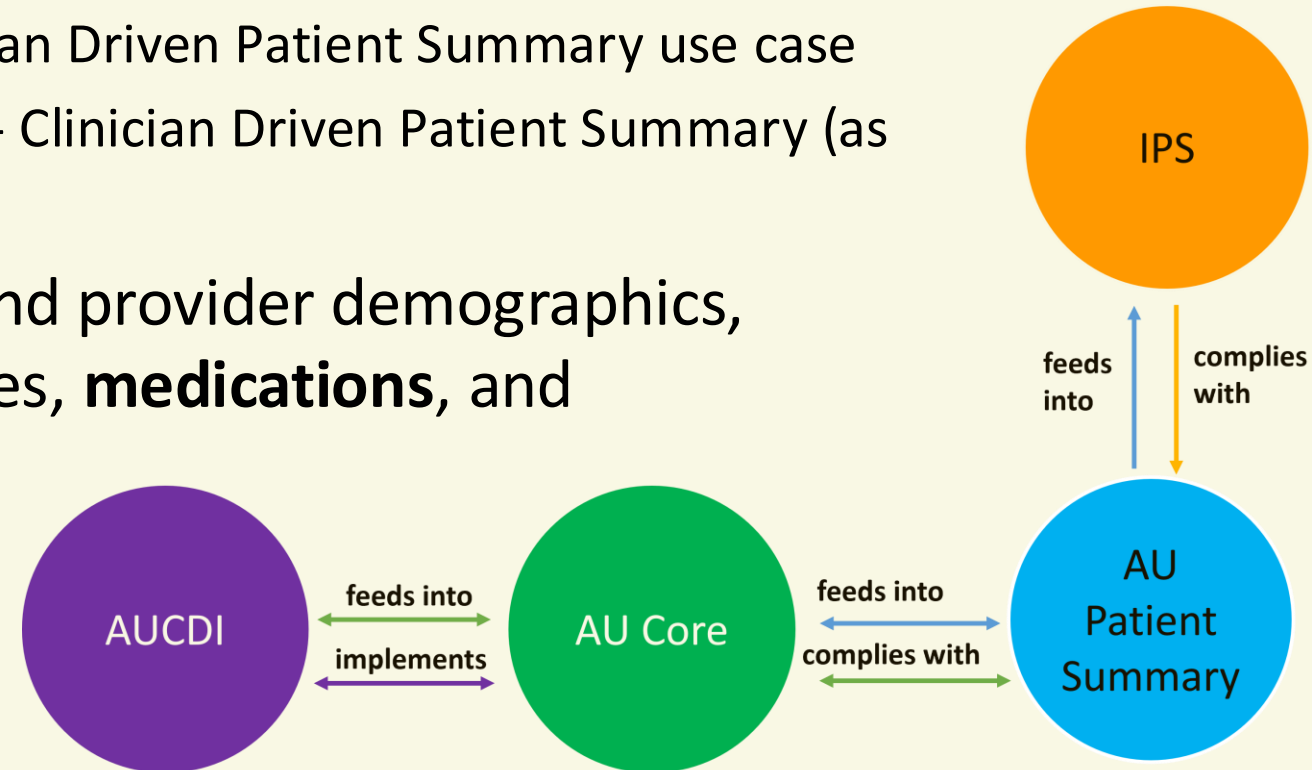
AU Core R2 Target Release Timeline

- Incremental enhancement of AU Core and support for downstream projects

- Intermediate draft snapshots for each HL7 AU Connectathon

- R2 Ballot for Working Standard in the August/September 2025 cycle

- Continued updates on a yearly / 15-monthly cycle from then on

AU PS R1 Target Release Timeline

- Intermediate draft snapshots for each HL7 AU Connectathon – starting March 2025

- R1 Ballot for Comment in the August/September 2025 cycle

- R1 Ballot for Working Standard in the February/March 2026 cycle,

- R1 Published June 2026
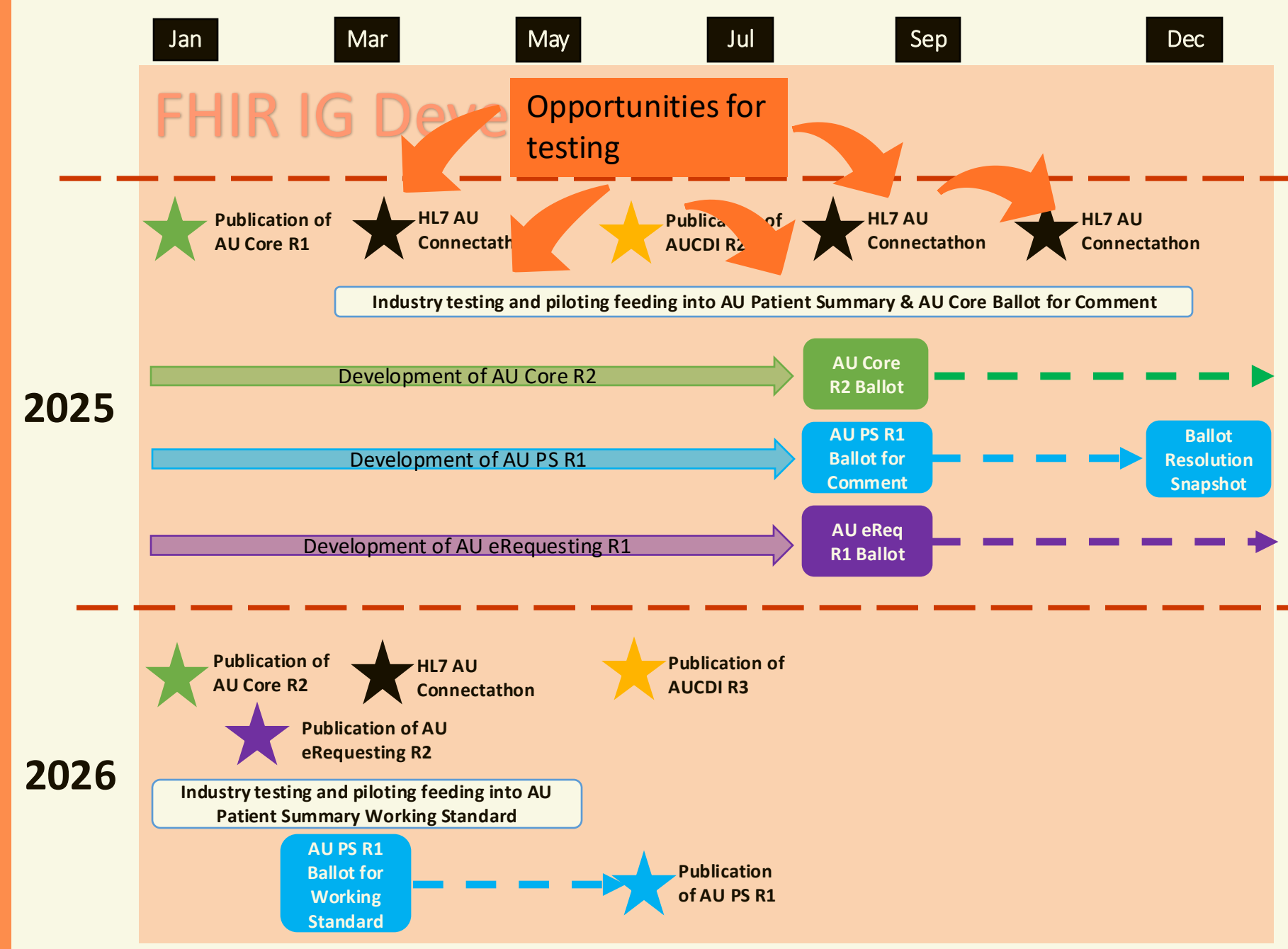
AU Patient Summary FHIR IG – draft is active!

Australian Digital Health Agency

Perspectives:
Mehmet Kavlakoglu

The newest addition to Sparked

"You mean in 2025, we don't allow consumers to include their story or goals in their patient summary?

Send me back"

Are we building a patient summary for today or tomorrow?

14 years old
1. Balanced nutrition
2. Regular exercise
3. Body image
4. Social skills

24 years old
1. Early intervention
2. Health screenings
3. Work life balance
4. Healthy relationships
5. Substance use

34 years old
1. Reproductive health
2. Caring responsibilities
3. Dental
4. Cosmetic procedures

44 years old
1. Chronic disease prevention
2. Bone health (supplementation)
3. Weight gain
4. Stress management

54 years old
1. Chronic disease management
2. Medication adherence
3. Diet and nutrition
4. Physical activity

64 years old
1. Mental acuity
2. Social skills and lifestyle
3. Hip replacement
4. Mobility
5. Retirement planning

74 years old
1. Grief
2. Medication management
3. Independent living
4. Advance care planning
5. Pain management

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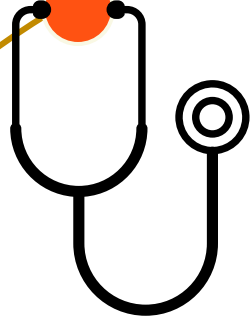
Best Practice

'Best practice' in medicine and healthcare is usually figured in relation with the paradigm of 'evidence-based medicine', which is described as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of **<u>individual</u>** *patients*

"...scholars have considered how the translation of best practice into individual clinical encounters is not a singular or straightforward process but rather requires a complex and situated negotiation of research evidence, organisational guidelines, practitioner expertise and experience, **<u>patient preferences</u>**, *and other socio-material elements"*

Striking a balance

Patient Story prepared by HCP

- Sally is a librarian who works long hours.

- She is a mother of two and is sometimes accompanied by her husband at medical appointments.

- She reports that she has irregular meal patterns and lacks time for exercise.

- She is not always compliant with her dosing schedule.

Patient Story prepared by Sally herself

- I've made some significant changes to my lifestyle since early 2024 after the birth of my first grandchild.

- I joined a local walking group, which not only helped me shed some weight but also **boosted my mood** and energy levels.

- I've always been someone who **believes** in staying active in the community, and my walking group buddies have become a part of that community.

- I've set some goals for myself. I want to get my diabetes under better control and **really focus** on taking my medications as prescribed. I also want to find a diet that works for me long-term

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Perspectives:
Grahame Grieve

Perspectives:
Harry Iles-Mann

Workshop 3: Activity 1 – Patient Story

- In your group, discuss and complete the worksheet at your table
  - What does a Patient Story mean to you?
  - What is the value of this for
    - Consumers
    - Carers
    - Clinicians, etc
  - What are the key use cases for a Patient Story?
    - What is the key information?
    - Narrative or structured? Coded?
  - What are the key considerations? (e.g. medico-legal, privacy)

Have a hairy question? Please note on a post it note!

As a **group** at your table

Menti time!
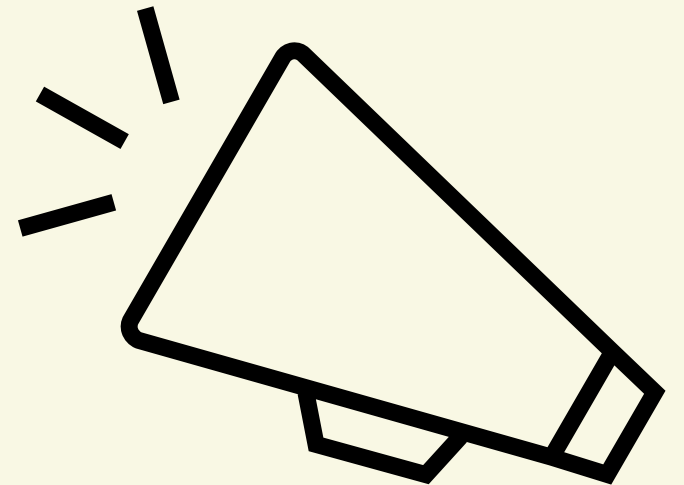
Thank you!

Hope to see some of you down at the pub!

Maltshovel TapHouse

Adelaide Festival Theatre
- At the end of the footbridge

See some of you tomorrow at the TDG!