Sparked
Chronic Condition Management Clinical Focus Group (CCM CFG)

Tuesday 3rd June 2025
11:00pm – 1:00pm

Australia's National Science Agency

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 Torres Strait Islander people, acknowledging the First Peoples as the first scientists, educators and healers.

'Eternal Wisdom, Infinite Innovation'
artwork by Rachael Sarra, working with Gilimbaa.

Agenda

Item	Topic
1	Welcome & general updates
3	Workshop activity 1: Detailed CCM Journey Timeline
4	Workshop activity 2: Chronic Condition Management Journey Wheels
5	Future meetings & upcoming events

Sparked HL7 FHIR

Please note: text in a blue box indicates quick notes recorded during the course of the meeting

Reminder that this meeting is being recorded

CCM CFG General Updates

[Sparked Chronic Condition Management Clinical Focus Group – Sparked]

[CCM CFG Meeting 1 (4 April 2025)]

[CCM CFG Meeting 2 (2 May 2025)]

[CCM CFG Meeting 3 (21 May 2025)]

Recordings of the Sparked Symposium recording are now available!

[Sparked Symposium: Sparking the FHIR recordings]

Sparked HL7 FHIR

Purpose of Chronic Condition Management Clinical Focus Group (CCM CFG)

- The Sparked Chronic Condition Management Clinical Focus Group (CCM CFG) is a **sub-group of the Sparked Clinical Design Group (CDG)**

- **Time limited** committee, subject to the Sparked program requirements

- Provide targeted clinical support to enable the development of **Chronic Condition Management priorities within the Sparked FHIR Accelerator,** e.g.
  - Create example clinical scenarios related to management of a chronic condition to help in the development of the AUCDI and FHIR Implementation Guides
  - Create materials to give clinical context & understanding to our technical or non-clinical community members

CCM CFG Scope

Clinical guidance and expertise on chronic condition management related user scenarios, workflows, data flows, challenges, opportunities, etc

Creation of journey(s) highlighting the complexities of chronic condition management.

Identifying considerations regarding chronic condition management template(s) which supports team care/shared care.

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

Support AUCDI development as required by the Sparked CDG

Assist in developing test data or materials to support clinical education and understanding of CCM (if required)

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CCM CFG – Out of Scope

AUCDI data groups

- This remain the remit of the Sparked CDG

FHIR Implementation Guides

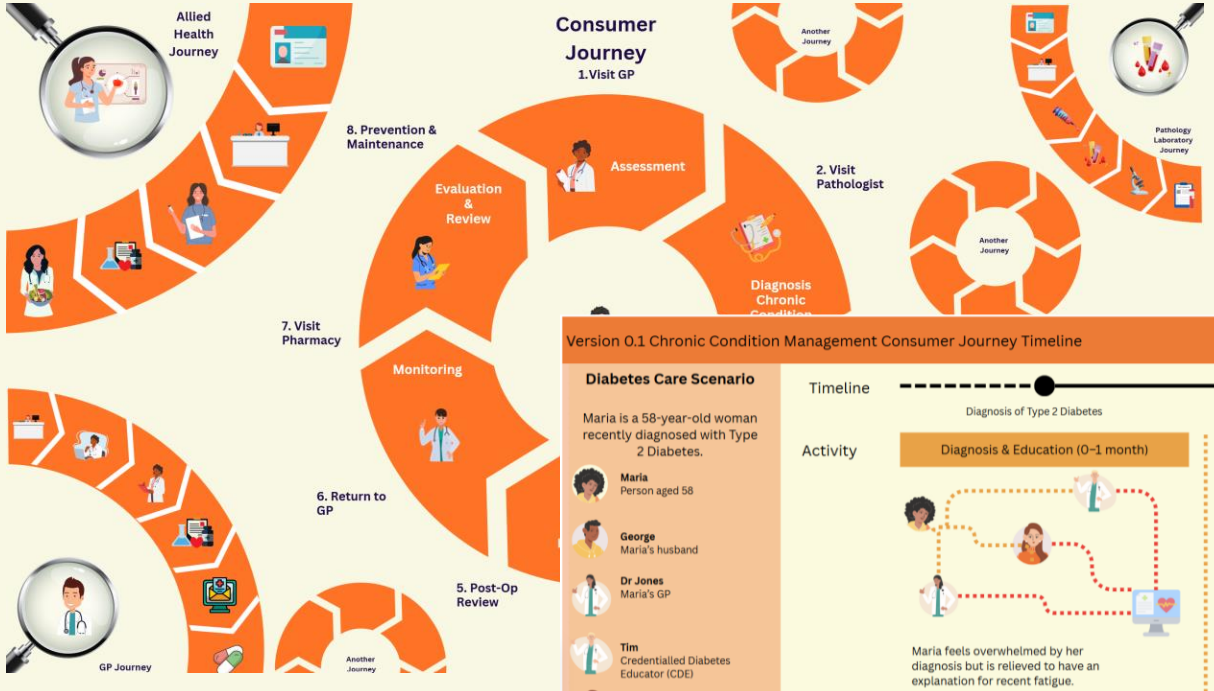
- These remain with the technical design group(s) and/or developers

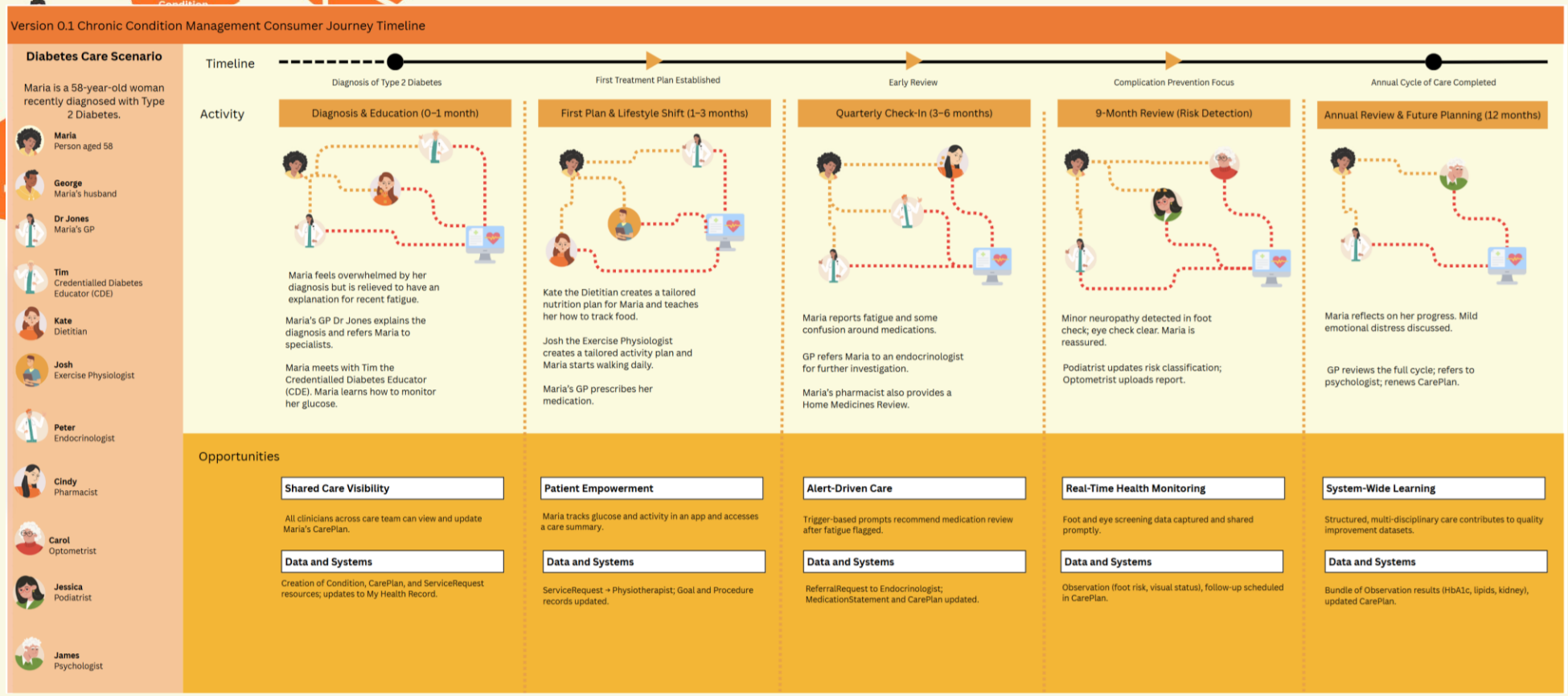
Broader policy discussions regarding reforms, implementations, funding arrangements etc. not within the scope of the Sparked FHIR Accelerator program.

Determining or defining specific clinical care pathways, guidelines, or treatment recommendations.

- **Materials developed in this forum are indicative clinical journeys or workflows, and do not specify a required or recommended clinical process or pathway.**
- **Not comprehensive or inclusive of all possible scenarios**

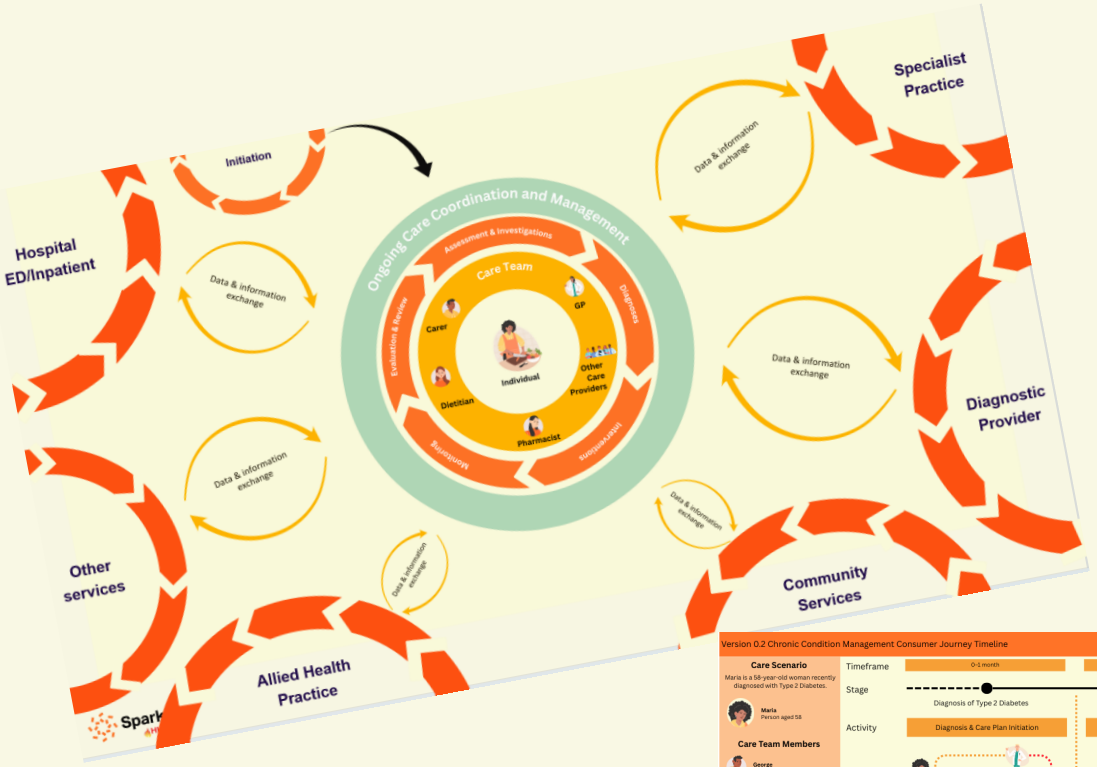
Meeting 2…

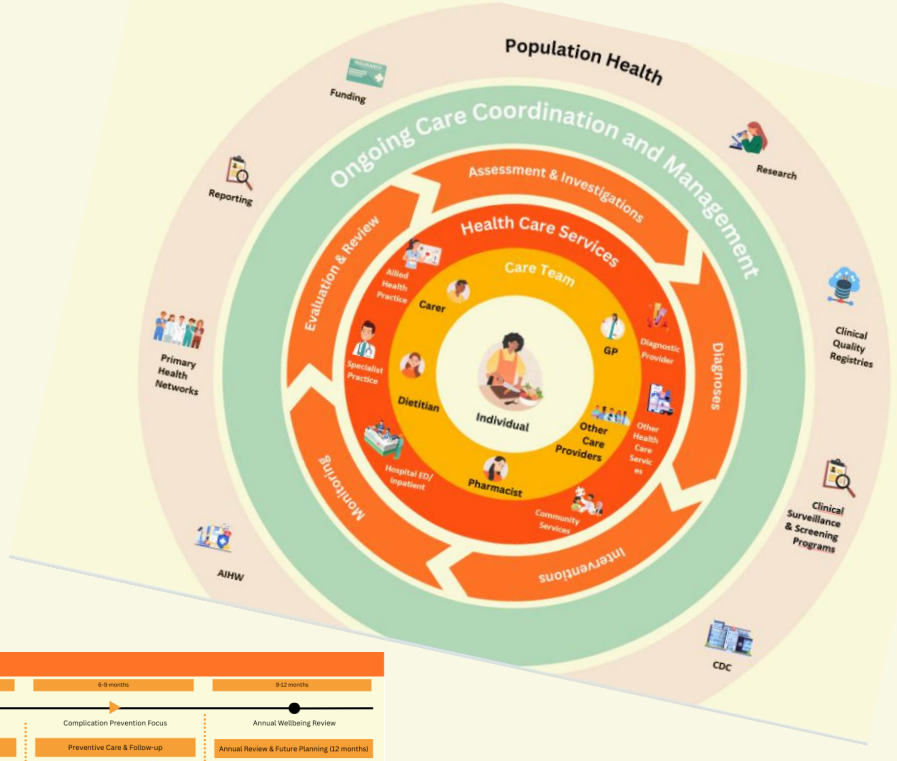


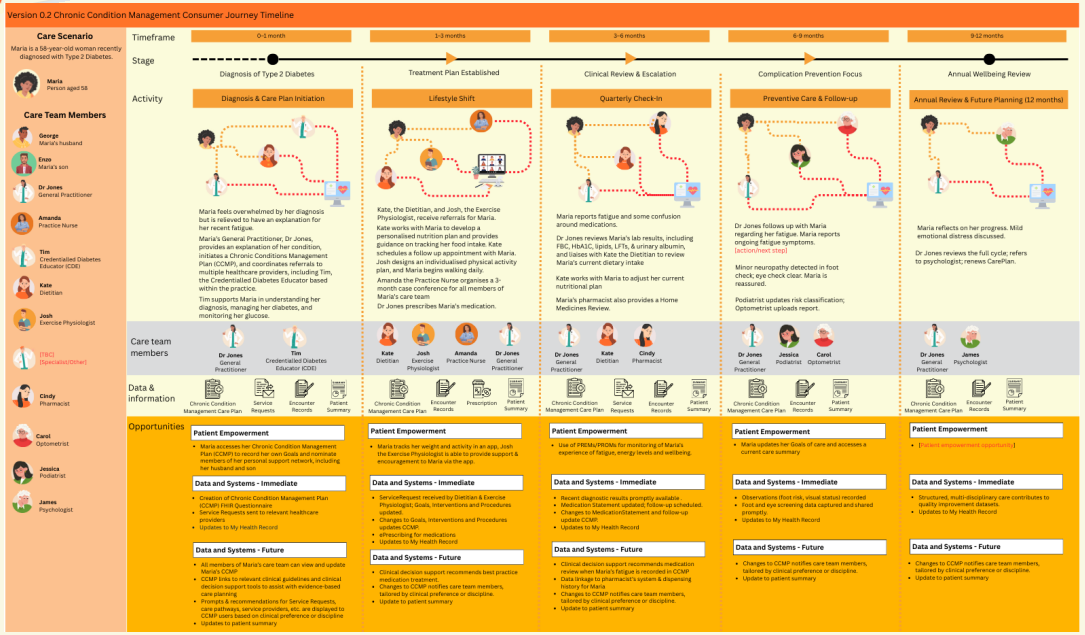


Sparked
HL7 FHIR

Meeting 3…







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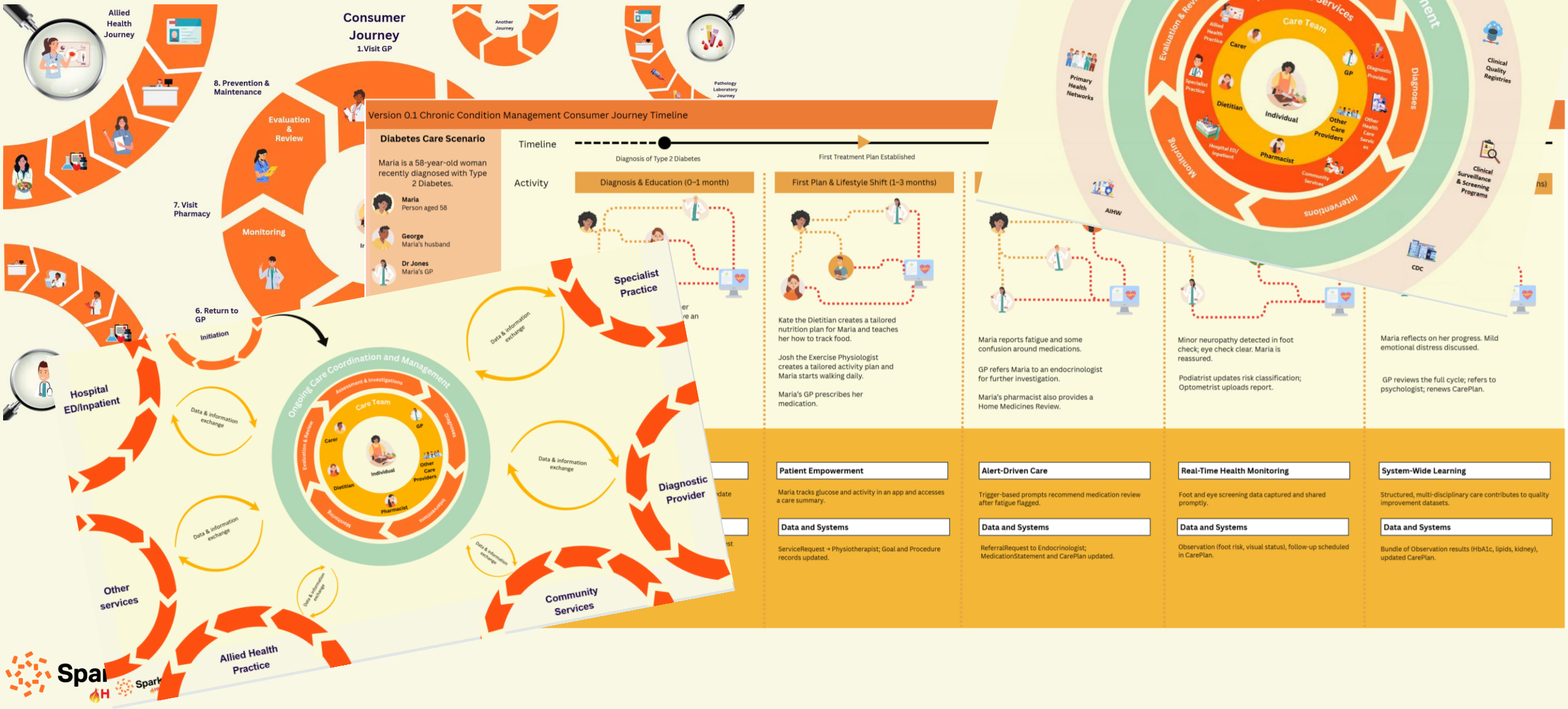
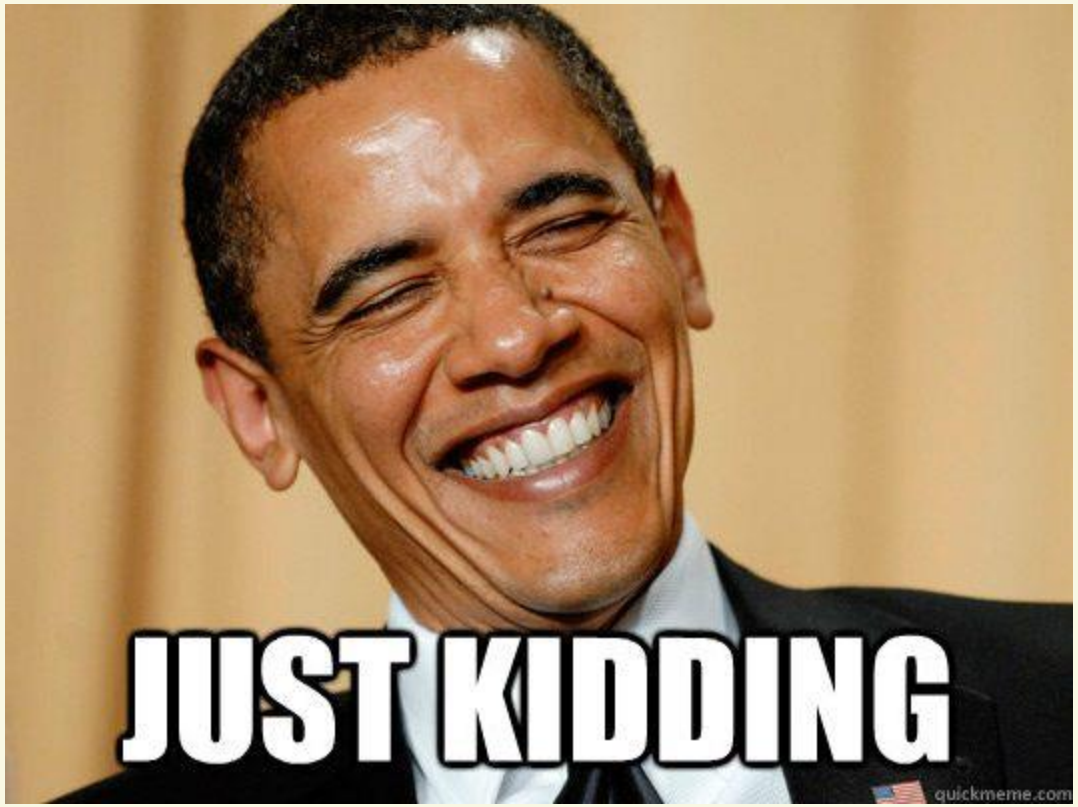
Meeting 4!


Allied Health Journey
Consumer Journey
1.Visit GP
Another Journey
Pathology Laboratory Journey
8. Prevention & Maintenance
Evaluation & Review
7. Visit Pharmacy
Monitoring
6. Return to GP
Initiation
Hospital ED/Inpatient
Other services
Allied Health Practice
Community Services
Diagnostic Provider
Specialist Practice
Data & information exchange
Ongoing Care Coordination and Management
Assessment & investigations
Care Team
Health Care Services
Diagnoses
Interventions
Monitoring
Evaluation & Review
Individual
Carer
GP
Dietitian
Pharmacist
Other Care Providers
Version 0.1 Chronic Condition Management Consumer Journey Timeline
Diabetes Care Scenario
Maria is a 58-year-old woman recently diagnosed with Type 2 Diabetes.
Maria
Person aged 58
George
Maria's husband
Dr Jones
Maria's GP
Timeline
Diagnosis of Type 2 Diabetes
First Treatment Plan Established
Activity
Diagnosis & Education (0–1 month)
First Plan & Lifestyle Shift (1–3 months)
Kate the Dietitian creates a tailored nutrition plan for Maria and teaches her how to track food.
Josh the Exercise Physiologist creates a tailored activity plan and Maria starts walking daily.
Maria's GP prescribes her medication.
Maria reports fatigue and some confusion around medications.
GP refers Maria to an endocrinologist for further investigation.
Maria's pharmacist also provides a Home Medicines Review.
Minor neuropathy detected in foot check; eye check clear. Maria is reassured.
Podiatrist updates risk classification; Optometrist uploads report.
Maria reflects on her progress. Mild emotional distress discussed.
GP reviews the full cycle; refers to psychologist; renews CarePlan.
Patient Empowerment
Maria tracks glucose and activity in an app and accesses a care summary.
Alert-Driven Care
Trigger-based prompts recommend medication review after fatigue flagged.
Real-Time Health Monitoring
Foot and eye screening data captured and shared promptly.
System-Wide Learning
Structured, multi-disciplinary care contributes to quality improvement datasets.
Data and Systems
ServiceRequest → Physiotherapist; Goal and Procedure records updated.
Data and Systems
ReferralRequest to Endocrinologist; MedicationStatement and CarePlan updated.
Data and Systems
Observation (foot risk, visual status), follow-up scheduled in CarePlan.
Data and Systems
Bundle of Observation results (HbA1c, lipids, kidney), updated CarePlan.
Population Health
Funding
Research
Reporting
Clinical Quality Registries
Primary Health Networks
Clinical Surveillance & Screening Programs
AIHW
CDC


JUST KIDDING
quickmeme.com

Workshop activity 1: Detailed CCM Journey Timeline

Name & age change!

- Other journey's currently being created where 'Maria' is the patient
- New persona selected from existing Sparked test data

- Name: **Caterina Foreman** (previously Maria)
- Age: **55 years old** (previously 58)

Chronic Condition Management Consumer Journey Timeline

Previous – v0.1

Version 0.1 Chronic Condition Management Consumer Journey Timeline

Diabetes Care Scenario

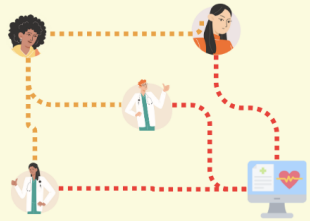
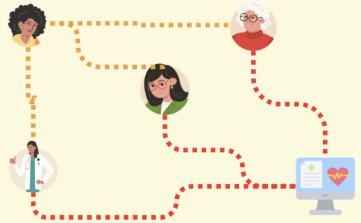
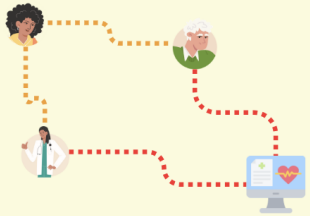
Maria is a 58-year-old woman recently diagnosed with Type 2 Diabetes.

- **Maria** — Person aged 58
- **George** — Maria's husband
- **Dr Jones** — Maria's GP
- **Tim** — Credentialled Diabetes Educator (CDE)
- **Kate** — Dietitian
- **Josh** — Exercise Physiologist
- **Peter** — Endocrinologist
- **Cindy** — Pharmacist
- **Carol** — Optometrist
- **Jessica** — Podiatrist
- **James** — Psychologist

Timeline

Diagnosis of Type 2 Diabetes	First Treatment Plan Established	Early Review	Complication Prevention Focus	Annual Cycle of Care Completed

Activity

Diagnosis & Education (0–1 month)	First Plan & Lifestyle Shift (1–3 months)	Quarterly Check-In (3–6 months)	9-Month Review (Risk Detection)	Annual Review & Future Planning (12 months)
				
Maria feels overwhelmed by her diagnosis but is relieved to have an explanation for recent fatigue. Maria's GP Dr Jones explains the diagnosis and refers Maria to specialists. Maria meets with Tim the Credentialled Diabetes Educator (CDE). Maria learns how to monitor her glucose.	Kate the Dietitian creates a tailored nutrition plan for Maria and teaches her how to track food. Josh the Exercise Physiologist creates a tailored activity plan and Maria starts walking daily. Maria's GP prescribes her medication.	Maria reports fatigue and some confusion around medications. GP refers Maria to an endocrinologist for further investigation. Maria's pharmacist also provides a Home Medicines Review.	Minor neuropathy detected in foot check; eye check clear. Maria is reassured. Podiatrist updates risk classification; Optometrist uploads report.	Maria reflects on her progress. Mild emotional distress discussed. GP reviews the full cycle; refers to psychologist; renews CarePlan.

Opportunities

Shared Care Visibility	Patient Empowerment	Alert-Driven Care	Real-Time Health Monitoring	System-Wide Learning
All clinicians across care team can view and update Maria's CarePlan.	Maria tracks glucose and activity in an app and accesses a care summary.	Trigger-based prompts recommend medication review after fatigue flagged.	Foot and eye screening data captured and shared promptly.	Structured, multi-disciplinary care contributes to quality improvement datasets.
Data and Systems	**Data and Systems**	**Data and Systems**	**Data and Systems**	**Data and Systems**
Creation of Condition, CarePlan, and ServiceRequest resources; updates to My Health Record.	ServiceRequest → Physiotherapist; Goal and Procedure records updated.	ReferralRequest to Endocrinologist; MedicationStatement and CarePlan updated.	Observation (foot risk, visual status), follow-up scheduled in CarePlan.	Bundle of Observation results (HbA1c, lipids, kidney), updated CarePlan.

Sparked HL7 FHIR

Chronic Condition Management Consumer Journey Timeline

Previous – v0.2

Version 0.2 Chronic Condition Management Consumer Journey Timeline

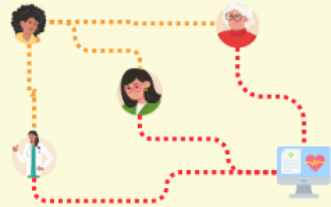
Care Scenario

Maria is a 58-year-old woman recently diagnosed with Type 2 Diabetes.

Maria
Person aged 58

Care Team Members

- **George** — Maria's husband
- **Enzo** — Maria's son
- **Dr Jones** — General Practitioner
- **Amanda** — Practice Nurse
- **Tim** — Credentialled Diabetes Educator (CDE)
- **Kate** — Dietitian
- **Josh** — Exercise Physiologist
- [TBC] [Specialist/Other]
- **Cindy** — Pharmacist
- **Carol** — Optometrist
- **Jessica** — Podiatrist
- **James** — Psychologist

	0–1 month	1–3 months	3–6 months	6–9 months	9–12 months
Stage	Diagnosis of Type 2 Diabetes	Treatment Plan Established	Clinical Review & Escalation	Complication Prevention Focus	Annual Wellbeing Review
Activity	Diagnosis & Care Plan Initiation	Lifestyle Shift	Quarterly Check-In	Preventive Care & Follow-up	Annual Review & Future Planning (12 months)
					
	Maria feels overwhelmed by her diagnosis but is relieved to have an explanation for her recent fatigue. Maria's General Practitioner, Dr Jones, provides an explanation of her condition, initiates a Chronic Conditions Management Plan (CCMP), and coordinates referrals to multiple healthcare providers, including Tim, the Credentialled Diabetes Educator based within the practice. Tim supports Maria in understanding her diagnosis, managing her diabetes, and monitoring her glucose.	Kate, the Dietitian, and Josh, the Exercise Physiologist, receive referrals for Maria. Kate works with Maria to develop a personalised nutrition plan and provides guidance on tracking her food intake. Kate schedules a follow up appointment with Maria. Josh designs an individualised physical activity plan, and Maria begins walking daily. Amanda the Practice Nurse organises a 3-month case conference for all members of Maria's care team Dr Jones prescribes Maria's medication.	Maria reports fatigue and some confusion around medications. Dr Jones reviews Maria's lab results, including FBC, HbA1C, lipids, LFTs, & urinary albumin, and liaises with Kate the Dietitian to review Maria's current dietary intake Kate works with Maria to adjust her current nutritional plan Maria's pharmacist also provides a Home Medicines Review.	Dr Jones follows up with Maria regarding her fatigue. Maria reports ongoing fatigue symptoms. [action/next step] Minor neuropathy detected in foot check; eye check clear. Maria is reassured. Podiatrist updates risk classification; Optometrist uploads report.	Maria reflects on her progress. Mild emotional distress discussed. Dr Jones reviews the full cycle; refers to psychologist; renews CarePlan.
Care team members	Dr Jones (General Practitioner); Tim (Credentialled Diabetes Educator (CDE))	Kate (Dietitian); Josh (Exercise Physiologist); Amanda (Practice Nurse); Dr Jones (General Practitioner)	Dr Jones (General Practitioner); Kate (Dietitian); Cindy (Pharmacist)	Dr Jones (General Practitioner); Jessica (Podiatrist); Carol (Optometrist)	Dr Jones (General Practitioner); James (Psychologist)
Data & information	Chronic Condition Management Care Plan; Service Requests; Encounter Records; Patient Summary	Chronic Condition Management Care Plan; Encounter Records; Prescription; Patient Summary	Chronic Condition Management Care Plan; Service Requests; Encounter Records; Patient Summary	Chronic Condition Management Care Plan; Encounter Records; Patient Summary	Chronic Condition Management Care Plan; Encounter Records; Patient Summary
Opportunities	**Patient Empowerment** • Maria accesses her Chronic Condition Management Plan (CCMP) to record her own Goals and nominate members of her personal support network, including her husband and son **Data and Systems - Immediate** • Creation of Chronic Condition Management Plan (CCMP) FHIR Questionnaire • Service Requests sent to relevant healthcare providers • Updates to My Health Record **Data and Systems - Future** • All members of Maria's care team can view and update Maria's CCMP • CCMP links to relevant clinical guidelines and clinical decision support tools to assist with evidence-based care planning • Prompts & recommendations for Service Requests, care pathways, service providers, etc. are displayed to CCMP users based on clinical preference or discipline • Updates to patient summary	**Patient Empowerment** • Maria tracks her weight and activity in an app, Josh the Exercise Physiologist is able to provide support & encouragement to Maria via the app. **Data and Systems - Immediate** • ServiceRequest received by Dietitian & Exercise Physiologist; Goals, Interventions and Procedures updated. • Changes to Goals, Interventions and Procedures updates CCMP. • ePrescribing for medications • Updates to My Health Record **Data and Systems - Future** • Clinical decision support recommends best practice medication treatment. • Changes to CCMP notifies care team members, tailored by clinical preference or discipline. • Update to patient summary	**Patient Empowerment** • Use of PREMs/PROMs for monitoring of Maria's experience of fatigue, energy levels and wellbeing. **Data and Systems - Immediate** • Recent diagnostic results promptly available . • Medication Statement updated; follow-up scheduled. • Changes to MedicationStatement and follow-up update CCMP. • Updates to My Health Record **Data and Systems - Future** • Clinical decision support recommends medication review when Maria's fatigue is recorded in CCMP • Data linkage to pharmacist's system & dispensing history for Maria • Changes to CCMP notifies care team members, tailored by clinical preference or discipline. • Update to patient summary	**Patient Empowerment** • Maria updates her Goals of care and accesses a current care summary **Data and Systems - Immediate** • Observations (foot risk, visual status) recorded • Foot and eye screening data captured and shared promptly. • Updates to My Health Record **Data and Systems - Future** • Changes to CCMP notifies care team members, tailored by clinical preference or discipline. • Update to patient summary	**Patient Empowerment** • [Patient empowerment opportunity] **Data and Systems - Immediate** • Structured, multi-disciplinary care contributes to quality improvement datasets. • Updates to My Health Record **Data and Systems - Future** • Changes to CCMP notifies care team members, tailored by clinical preference or discipline. • Update to patient summary

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Chronic Condition Management Consumer Journey Timeline

Updated

Version 0.3 Chronic Condition Management Consumer Journey Timeline

Care Scenario

Caterina is a 55-year-old woman recently diagnosed with Type 2 Diabetes.

Caterina
Person aged 55

Care Team Members

- **George** — Caterina's husband
- **Enzo** — Caterina's son
- **Dr Jones** — General Practitioner
- **Amanda** — Practice Nurse
- **Tim** — Credentialled Diabetes Educator (CDE)
- **Kate** — Dietitian
- **Josh** — Exercise Physiologist
- **Cindy** — Pharmacist
- **Carol** — Optometrist
- **Jessica** — Podiatrist
- **James** — Psychologist
- **Bryce** — Endocrinologist

	0–1 month	1–3 months	3–6 months	6–9 months	9–12 months
Stage	Diagnosis of Type 2 Diabetes	Treatment Plan Established	Clinical Review & Escalation	Complication Prevention Focus	Wellbeing Review
Activity	Diagnosis & Care Plan Initiation	Lifestyle Shift	Quarterly Check-In	Preventive Care & Follow-up	Emotional Wellbeing Support (12 months)
					
	Caterina feels overwhelmed by her diagnosis but is relieved to have an explanation for her recent fatigue. Caterina's General Practitioner, Dr Jones, provides an explanation of her condition, initiates a Chronic Conditions Management Plan (CCMP), and coordinates referrals to multiple healthcare providers, including Tim, the Credentialled Diabetes Educator based within the practice. Tim supports Caterina in understanding her diagnosis, managing her diabetes, and monitoring her glucose. Dr Jones refers Caterina to a Dietitian and an Exercise Physiologist	Kate the Dietitian works with Caterina to develop a personalised nutrition plan and provides guidance on tracking her food intake. Kate schedules a follow up appointment with Caterina. Josh the Exercise Physiologist designs an individualised physical activity plan with Caterina. Amanda the Practice Nurse administers Caterina's yearly influenza vaccination, updates Caterina's care plan and organises a 3-month case conference for all members of Caterina's care team. Dr Jones reviews Caterina's care plan and notes Caterina's blood glucose levels remain outside target range. Dr Jones adjusts Caterina's current medications, requests updated blood tests and arranges a follow-up visit to monitor progress.	Caterina presents to Dr Jones with some questions regarding her medications. Caterina reports that she has been experiencing diarrhoea when taking Metformin and has stopped using it. Dr Jones assesses Caterina, checks her recent lab results and reviews her current list of medications. Dr Jones agrees with ceasing Caterina's Metformin, and also liaises with Tim the Credentialled Diabetes Educator to provide additional support and education to Caterina. Caterina's pharmacist, Cindy, undertakes a Home Medicines Review, provides additional education to Caterina regarding her current medications and identifies an over-the-counter supplement that Caterina has been taking.	Dr Jones follows up with Caterina regarding her previously reported diarrhoea. Caterina confirms her diarrhoea has resolved. During the visit, Dr Jones also identifies Caterina's recent blood glucose levels are above target range. Dr Jones liaises with Kate the Dietitian to review Caterina's current dietary intake and provide guidance to support glycaemic control. Dr Jones also sends a referral to Caterina's optometrist, Carol, to check her eye health. Kate works with Caterina to adjust her nutritional plan. Carol undertakes a comprehensive eye exam; no issues identified. Caterina also attends a routine foot check-up with Jessica the Podiatrist. Minor neuropathy detected during foot exam. Jessica document her findings and liaises with Dr Jones regarding ongoing monitoring & follow-up.	At Caterina's next appointment, Dr Jones observes a shift in her emotional state and reviews Caterina's recent PROMs results. Caterina's son also expresses concern about recent changes in her behaviour. Caterina shares that she has been feeling overwhelmed, stressed, and is finding it difficult to cope with the demands of managing her condition. Amanda the Practice Nurse and Dr Jones work closely together to arrange regular check-ins that include Caterina's son and husband, to monitor Caterina's emotional wellbeing and ensure her support network remains actively involved in her care. Dr Jones also refers Caterina to James, the Psychologist. Together, James and Caterina explore her current emotional state, to develop coping strategies and manage the impact of her chronic condition. Caterina reflects on her progress and experience over the past year
Care team members	Dr Jones (General Practitioner); Tim (Credentialled Diabetes Educator (CDE))	Kate (Dietitian); Josh (Exercise Physiologist); Amanda (Practice Nurse); Dr Jones (General Practitioner)	Dr Jones (General Practitioner); Tim (Credentialled Diabetes Educator (CDE)); Cindy (Pharmacist)	Dr Jones (General Practitioner); Kate (Dietitian); Carol (Optometrist); Jessica (Podiatrist)	Dr Jones (General Practitioner); Enzo (Caterina's son); Amanda (Practice Nurse); James (Psychologist)
Data & information	Chronic Condition Management Care Plan; Encounter Records; Patient Summary; Service Requests	Chronic Condition Management Care Plan; Encounter Records; Patient Summary; Prescription	Chronic Condition Management Care Plan; Encounter Records; Patient Summary; Service Requests	Chronic Condition Management Care Plan; Encounter Records; Patient Summary; Service Requests	Chronic Condition Management Care Plan; Encounter Records; Patient Summary; Service Requests
Opportunities	**Patient Empowerment** • Caterina accesses her Chronic Condition Management Plan (CCMP) to record her own Goals and nominate members of her personal support network, including her husband and son **Data and Systems - Immediate** • Creation of Chronic Condition Management Plan (CCMP) FHIR Questionnaire • Service Requests sent to relevant healthcare providers • **Encounter record information readily accessible & exchangeable to My Health Record** **Data and Systems - Future** • All members of Caterina's care team can view and update Caterina's CCMP • CCMP links to relevant clinical guidelines and clinical decision support tools to assist with evidence-based care planning • Prompts & recommendations for Service Requests, care pathways, service providers, etc. are displayed to CCMP users based on clinical preference or discipline • Encounter record information readily accessible & exchangeable to update AU patient summary information	**Patient Empowerment** • Caterina tracks her weight and activity in an app, Josh the Exercise Physiologist is able to provide support & encouragement to Caterina via the app. **Data and Systems - Immediate** • ServiceRequest received by Dietitian & Exercise Physiologist; Goals, Interventions and Procedures updated. • Changes to Goals, Interventions and Procedures & Food and nutrition summary updates CCMP. • ePrescribing for medications • Encounter record information readily accessible & exchangeable to My Health Record **Data and Systems - Future** • All members of Caterina's care team can view and update Caterina's CCMP • Clinical decision support recommends best practice medication treatment, relevant diagnostic tests & timeframe to arrange follow-up • Changes to CCMP notifies care team members, tailored by clinical preference or discipline. • Encounter record information readily accessible & exchangeable to update AU patient summary information	**Patient Empowerment** • Use of PROMs for monitoring of Caterina's health status and wellbeing. **Data and Systems - Immediate** • Recent diagnostic results promptly available . • Follow-up scheduled. • Changes to Problem/diagnosis and Medication statement updates CCMP. • Encounter record information readily accessible & exchangeable to My Health Record **Data and Systems - Future** • All members of Caterina's care team can view and update Caterina's CCMP • When Caterina's symptoms are recorded in CCMP, clinical decision support recommends medication review, relevant diagnostic tests & timeframe to arrange follow-up. • Data linkage to pharmacist's system & dispensing history for Caterina. • Changes to CCMP notifies care team members, tailored by clinical preference or discipline. • Encounter record information readily accessible & exchangeable to update AU patient summary information	**Patient Empowerment** • Caterina updates her goals of care and accesses a current care summary **Data and Systems - Immediate** • Changes to Problem/diagnosis, Food and nutrition summary and Follow-up updates CCMP. • Observations (foot risk, visual status) recorded • Foot and eye screening data captured and shared promptly. • Encounter record information readily accessible & exchangeable to My Health Record **Data and Systems - Future** • All members of Caterina's care team can view and update Caterina's CCMP • Changes to CCMP notifies care team members, tailored by clinical preference or discipline. • Encounter record information readily accessible & exchangeable to update AU patient summary information	**Patient Empowerment** • Ongoing use of PROMs monitors Caterina's wellbeing over time, and enables Caterina's care team to tailor their approaches to her specific needs and preferences. **Data and Systems - Immediate** • Structured, multi-disciplinary care contributes to quality improvement datasets. • Encounter record information readily accessible & exchangeable to My Health Record **Data and Systems - Future** • All members of Caterina's care team can view and update Caterina's CCMP • Changes to CCMP notifies care team members, tailored by clinical preference or discipline. • Encounter record information readily accessible & exchangeable to update AU patient summary information

Sparked HL7 FHIR

Story/Journey

Updated

	0–1 month	1–3 months	3–6 months	6-9 months	9-12 months
Timeframe					
Stage	Diagnosis of Type 2 Diabetes	Treatment Plan Established	Clinical Review & Escalation	Complication Prevention Focus	Wellbeing Review
Activity	Diagnosis & Care Plan Initiation	Lifestyle Shift	Quarterly Check-In	Preventive Care & Follow-up	Emotional Wellbeing Support (12 months)
Care team members	**Dr Jones** General Practitioner **Tim** Credentialled Diabetes Educator (CDE)	**Kate** Dietitian **Josh** Exercise Physiologist **Amanda** Practice Nurse **Dr Jones** General Practitioner	**Dr Jones** General Practitioner **Tim** Credentialled Diabetes Educator (CDE) **Cindy** Pharmacist	**Dr Jones** General Practitioner **Kate** Dietitian **Carol** Optometrist **Jessica** Podiatrist	**Dr Jones** General Practitioner **Enzo** Caterina's son **Amanda** Practice Nurse **James** Psychologist
Data & information	Chronic Condition Management Care Plan Encounter Records Patient Summary Service Requests	Chronic Condition Management Care Plan Encounter Records Patient Summary Prescription	Chronic Condition Management Care Plan Encounter Records Patient Summary Service Requests	Chronic Condition Management Care Plan Encounter Records Patient Summary Service Requests	Chronic Condition Management Care Plan Encounter Records Patient Summary Service Requests

Caterina feels overwhelmed by her diagnosis but is relieved to have an explanation for her recent fatigue.

Caterina's General Practitioner, Dr Jones, provides an explanation of her condition, initiates a Chronic Conditions Management Plan (CCMP), and coordinates referrals to multiple healthcare providers, including Tim, the Credentialled Diabetes Educator based within the practice.

Tim supports Caterina in understanding her diagnosis, managing her diabetes, and monitoring her glucose.

Dr Jones refers Caterina to a Dietitian and an Exercise Physiologist

Kate the Dietitian works with Caterina to develop a personalised nutrition plan and provides guidance on tracking her food intake. Kate schedules a follow up appointment with Caterina.

Josh the Exercise Physiologist designs an individualised physical activity plan with Caterina.

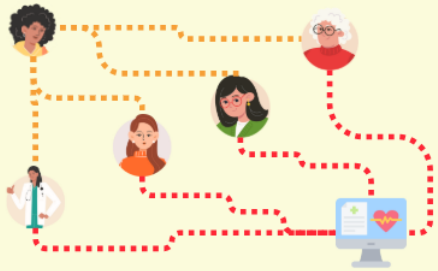
Amanda the Practice Nurse administers Caterina's yearly influenza vaccination, updates Caterina's care plan and organises a 3-month case conference for all members of Caterina's care team.

Dr Jones reviews Caterina's care plan and notes Caterina's blood glucose levels remain outside target range. Dr Jones adjusts Caterina's current medications, requests updated blood tests and arranges a follow-up visit to monitor progress.

Caterina presents to Dr Jones with some questions regarding her medications. Caterina reports that she has been experiencing diarrhoea when taking Metformin and has stopped using it.

Dr Jones assesses Caterina, checks her recent lab results and reviews her current list of medications. Dr Jones agrees with ceasing Caterina's Metformin, and also liaises with Tim the Credentialled Diabetes Educator to provide additional support and education to Caterina.

Caterina's pharmacist, Cindy, undertakes a Home Medicines Review, provides additional education to Caterina regarding her current medications and identifies an over-the-counter supplement that Caterina has been taking.

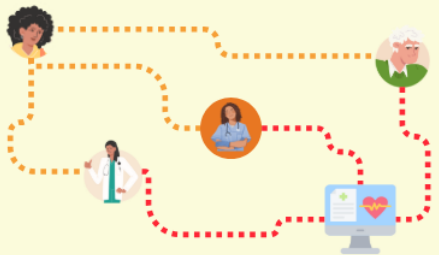


Dr Jones follows up with Caterina regarding her previously reported diarrhoea. Caterina confirms her diarrhoea has resolved. During the visit, Dr Jones also identifies Caterina's recent blood glucose levels are above target range.

Dr Jones liaises with Kate the Dietitian to review Caterina's current dietary intake and provide guidance to support glycaemic control. Dr Jones also sends a referral to Caterina's optometrist, Carol, to check her eye health.

Kate works with Caterina to adjust her nutritional plan. Carol undertakes a comprehensive eye exam; no issues identified.

Caterina also attends a routine foot check-up with Jessica the Podiatrist. Minor neuropathy detected during foot exam. Jessica document her findings and liaises with Dr Jones regarding ongoing monitoring & follow-up.



At Caterina's next appointment, Dr Jones observes a shift in her emotional state and reviews Caterina's recent PROMs results. Caterina's son also expresses concern about recent changes in her behaviour. Caterina shares that she has been feeling overwhelmed, stressed, and is finding it difficult to cope with the demands of managing her condition.

Amanda the Practice Nurse and Dr Jones work closely together to arrange regular check-ins that include Caterina's son and husband, to monitor Caterina's emotional wellbeing and ensure her support network remains actively involved in her care.

Dr Jones also refers Caterina to James, the Psychologist. Together, James and Caterina explore her current emotional state, to develop coping strategies and manage the impact of her chronic condition.

Caterina reflects on her progress and experience over the past year

Opportunities

Updated

Patient Empowerment

- Caterina accesses her Chronic Condition Management Plan (CCMP) to record her own Goals and nominate members of her personal support network, including her husband and son

Data and Systems - Immediate

- Creation of Chronic Condition Management Plan (CCMP) FHIR Questionnaire
- Service Requests sent to relevant healthcare providers
- **Encounter record information readily accessible & exchangeable to My Health Record**

Data and Systems - Future

- All members of Caterina's care team can view and update Caterina's CCMP
- CCMP links to relevant clinical guidelines and clinical decision support tools to assist with evidence-based care planning
- Prompts & recommendations for Service Requests, care pathways, service providers, etc. are displayed to CCMP users based on clinical preference or discipline
- Encounter record information readily accessible & exchangeable to update AU patient summary information

Patient Empowerment

- Caterina tracks her weight and activity in an app, Josh the Exercise Physiologist is able to provide support & encouragement to Caterina via the app.

Data and Systems - Immediate

- ServiceRequest received by Dietitian & Exercise Physiologist; Goals, Interventions and Procedures updated.
- Changes to Goals, Interventions and Procedures & Food and nutrition summary updates CCMP.
- ePrescribing for medications
- Encounter record information readily accessible & exchangeable to My Health Record

Data and Systems - Future

- All members of Caterina's care team can view and update Caterina's CCMP
- Clinical decision support recommends best practice medication treatment, relevant diagnostic tests & timeframe to arrange follow-up
- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Encounter record information readily accessible & exchangeable to update AU patient summary information

Patient Empowerment

- Use of PROMs for monitoring of Caterina's health status and wellbeing.

Data and Systems - Immediate

- Recent diagnostic results promptly available .
- Follow-up scheduled.
- Changes to Problem/diagnosis and Medication statement updates CCMP.
- Encounter record information readily accessible & exchangeable to My Health Record

Data and Systems - Future

- All members of Caterina's care team can view and update Caterina's CCMP
- When Caterina's symptoms are recorded in CCMP, clinical decision support recommends medication review, relevant diagnostic tests & timeframe to arrange follow-up.
- Data linkage to pharmacist's system & dispensing history for Caterina.
- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Encounter record information readily accessible & exchangeable to update AU patient summary information

Patient Empowerment

- Caterina updates her goals of care and accesses a current care summary

Data and Systems - Immediate

- Changes to Problem/diagnosis, Food and nutrition summary and Follow-up updates CCMP.
- Observations (foot risk, visual status) recorded
- Foot and eye screening data captured and shared promptly.
- Encounter record information readily accessible & exchangeable to My Health Record

Data and Systems - Future

- All members of Caterina's care team can view and update Caterina's CCMP
- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Encounter record information readily accessible & exchangeable to update AU patient summary information

Patient Empowerment

- Ongoing use of PROMs monitors Caterina's wellbeing over time, and enables Caterina's care team to tailor their approaches to her specific needs and preferences.

Data and Systems - Immediate

- Structured, multi-disciplinary care contributes to quality improvement datasets.
- Encounter record information readily accessible & exchangeable to My Health Record

Data and Systems - Future

- All members of Caterina's care team can view and update Caterina's CCMP
- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Encounter record information readily accessible & exchangeable to update AU patient summary information

Side Panel (Case Scenario & Care Team)

Updated

Additional: Wound healing/ ulcers – wound specialist/ nurse service

Need to note that non-exhaustive (rather than delving into detail)

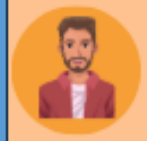
Care Scenario

Caterina is a 55-year-old woman recently diagnosed with Type 2 Diabetes.

Caterina
Person aged 55

Care Team Members

George
Caterina's husband



Enzo
Caterina's son

Dr Jones
General Practitioner

Amanda
Practice Nurse

Tim
Credentialled Diabetes Educator (CDE)

Kate
Dietitian

Josh
Exercise Physiologist

Cindy
Pharmacist

Carol
Optometrist

Jessica
Podiatrist

James
Psychologist

Bryce
Endocrinologi

George – appears to have no role – can we express this better (swap with enzo in the story?)

Question for the CFG

Even though they are not referenced in the patient journey – **should an Endocrinologist be included as a member of Caterina's Care Team?**

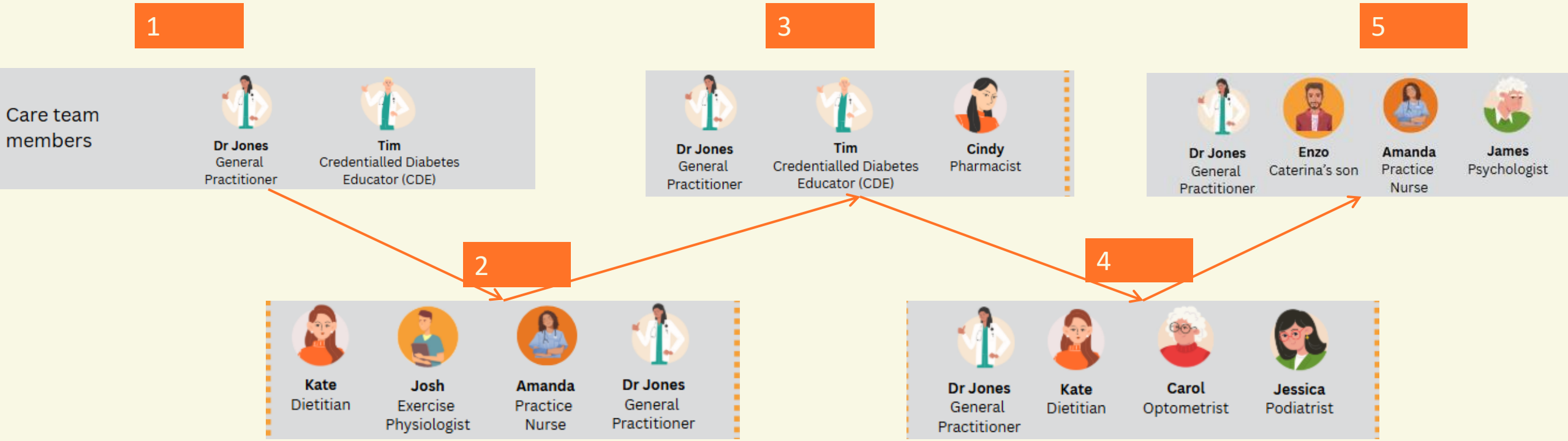
Feedback: If patient's diabetes is well controlled enough – may not ever need to see a specialist (e.g. cardio, gastro, endo/ophthalmologist, nephro, etc....) – not necessary for the first 12 months..
Perhaps add optional/extended care team/for future consideration – cardio more common than endo

Sparked HL7 FHIR

Care team members per stage

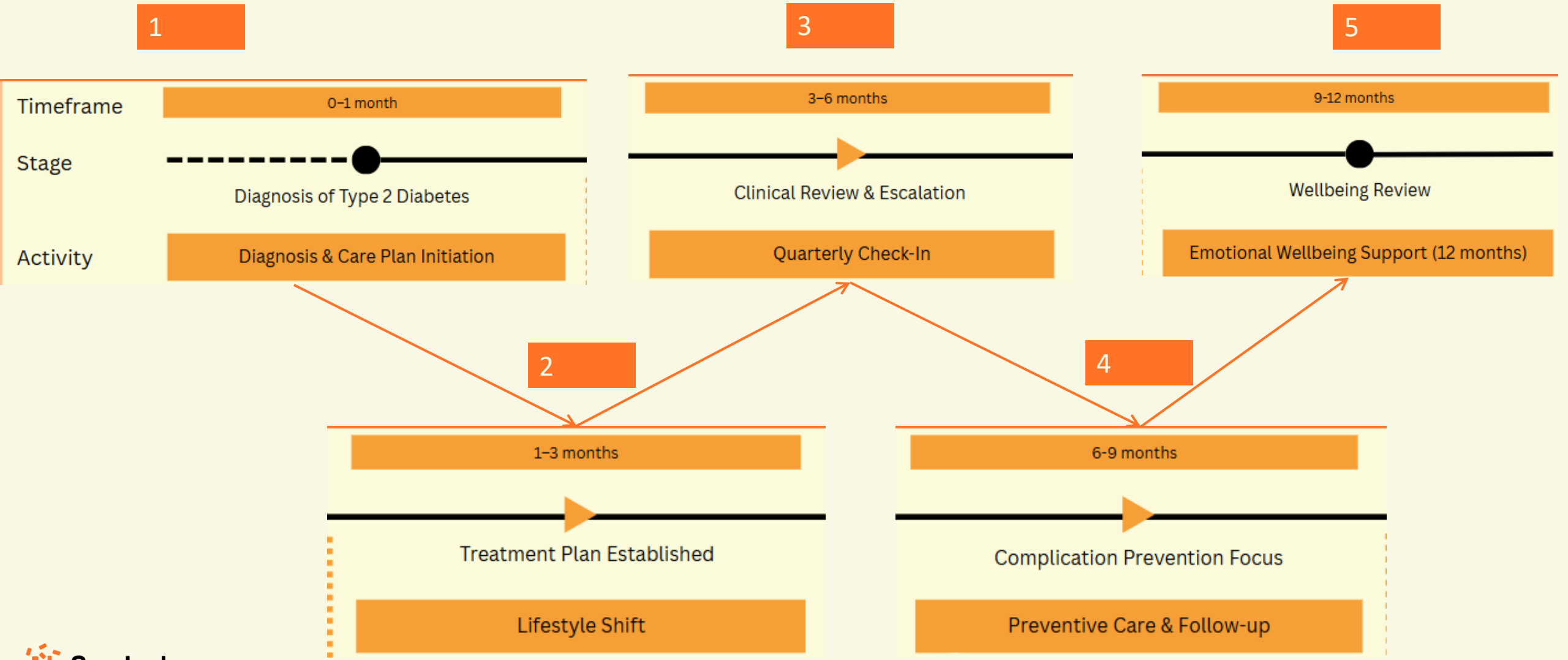
Updated

- Active team members for each stage
- Refer to side panel for full care team



Sparked HL7 FHIR

Timeframe, Stage, Activity



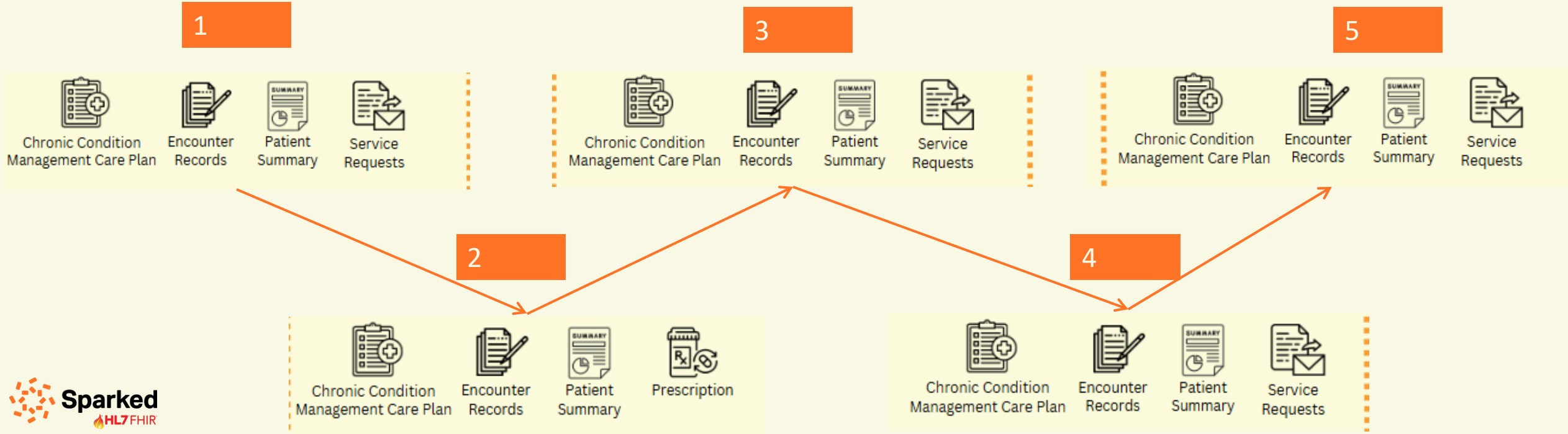
Sparked HL7 FHIR

Data & information section

- Represents artefacts created, updated, accessed/viewed
- Service requests, e.g. referrals, diagnostic requests, procedures or intervention request etc
- Encounter record types, e.g. Consult note, Specialist/AH letters, clinical/progress note, etc

Feedback & changes

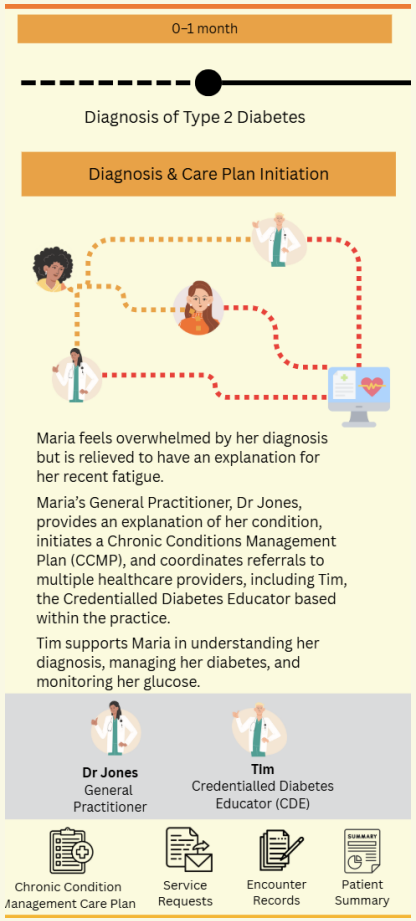
- Make the order of the artefacts the same throughout, i.e. CCMP, Encounter records, Patient summary grouped together



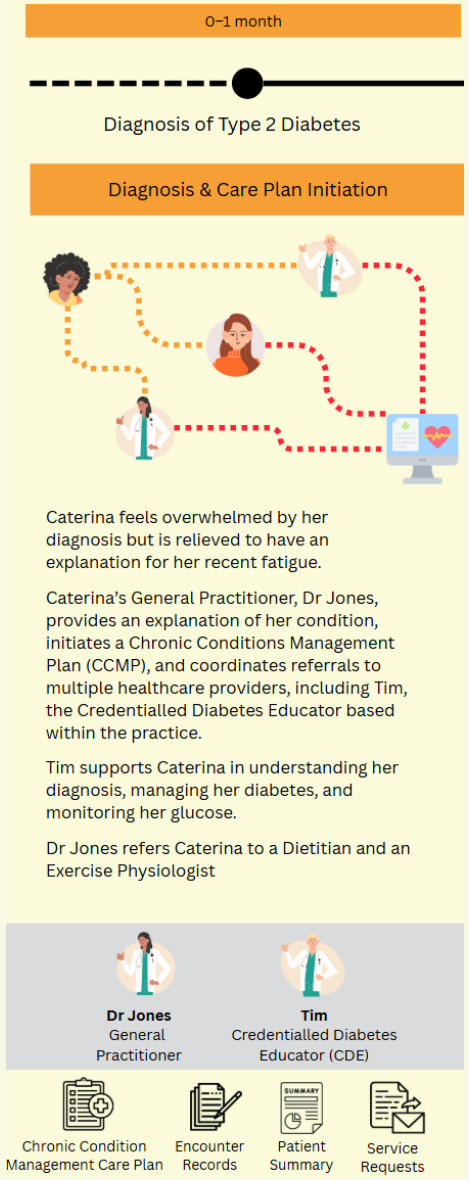
Sparked HL7 FHIR

CCM Timeline: Stage 1

Previous



Updated



Feedback & Changes

- Wording updated and moved from Stage 2 to Stage 1

Kate, the Dietitian, and Josh, the Exercise Physiologist, receive referrals for Maria. — Old

Dr Jones refers Caterina to a Dietitian and an Exercise Physiologist — New

Sparked HL7 FHIR

CCM Timeline: Stage 1 - Description

Caterina feels overwhelmed by her diagnosis but is relieved to have an explanation for her recent fatigue.

Caterina's General Practitioner, Dr Jones, provides an explanation of her condition, initiates a Chronic Conditions Management Plan (CCMP), and coordinates referrals to multiple healthcare providers, including Tim, the Credentialled Diabetes Educator based within the practice.

Tim supports Caterina in understanding her diagnosis, managing her diabetes, and monitoring her glucose.

Dr Jones refers Caterina to a Dietitian and an Exercise Physiologist

Notes:

Names for all the actors - ? If space permits?

"based within the practice" – is this useful – can remove the words?

- Reasonable either way :D

Dr Jones - switch to a first name? (when decide what her name is)

typo – CCMPs

CCM Timeline: Stage 1

Previous

Opportunities

Patient Empowerment

- Maria accesses her Chronic Condition Management Plan (CCMP) to record her own Goals and nominate members of her personal support network, including her husband and son

Data and Systems - Immediate

- Creation of Chronic Condition Management Plan (CCMP) FHIR Questionnaire
- Service Requests sent to relevant healthcare providers
- Updates to My Health Record

Data and Systems - Future

- All members of Maria's care team can view and update Maria's CCMP
- CCMP links to relevant clinical guidelines and clinical decision support tools to assist with evidence-based care planning
- Prompts & recommendations for Service Requests, care pathways, service providers, etc. are displayed to CCMP users based on clinical preference or discipline
- Updates to patient summary

Updated

Patient Empowerment

- Caterina accesses her Chronic Condition Management Plan (CCMP) to record her own Goals and nominate members of her personal support network, including her husband and son

Data and Systems - Immediate

- Creation of Chronic Condition Management Plan (CCMP) FHIR Questionnaire
- Service Requests sent to relevant healthcare providers
- **Encounter record information readily accessible & exchangeable to My Health Record**

Data and Systems - Future

- All members of Caterina's care team can view and update Caterina's CCMP
- CCMP links to relevant clinical guidelines and clinical decision support tools to assist with evidence-based care planning
- Prompts & recommendations for Service Requests, care pathways, service providers, etc. are displayed to CCMP users based on clinical preference or discipline
- Encounter record information readily accessible & exchangeable to update AU patient summary information

Feedback & Changes

- Updates to My Health Record – wording updated in alignment with patient summary changes below
- Updates to patient summary – consider better wording so it is clearer

• Updates to patient summary	Old
• Encounter record information readily accessible & exchangeable to update AU patient summary information	New

- Broader 'policy'/ 'hairy' question recorded:

*Can a **consumer update their own CCM/PS** – to correct, to add new, to update? If yes – how is this managed, what are the implications of this, how do we show the provenance of this change?*

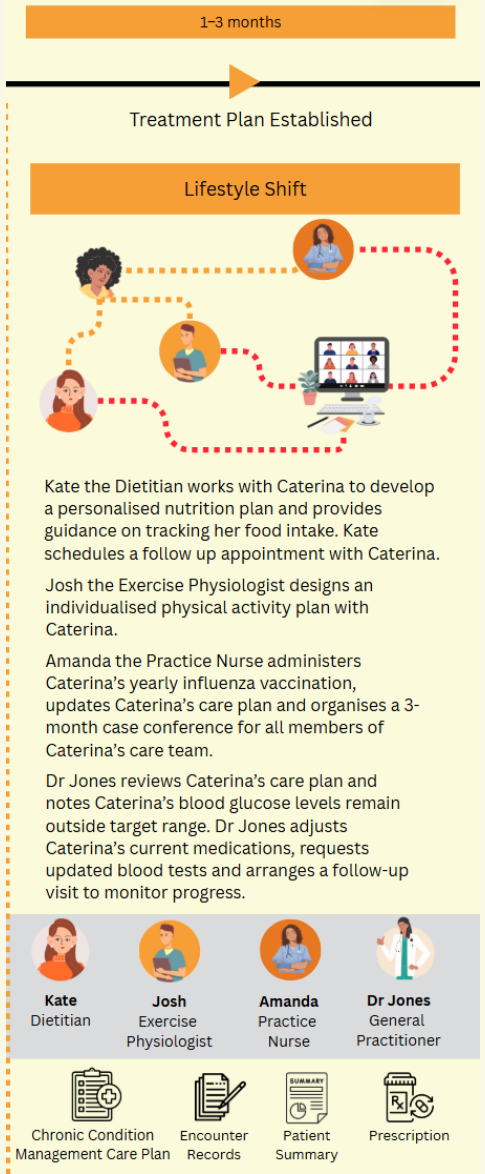
Should AU patient summary be capitalised ie. AU Patient Summary, or change to Australian patient summary

Sparked HL7 FHIR

CCM Timeline: Stage 2

Previous

Updated



Feedback & Changes

- Dr Jones does more than prescriptions, reviewing overall care, ensure patient seeing the right ppl at the right time, overseeing/initiating care and managing meds
  - Journey updated
- Practice nurse – more than just organising case conf. Incorporate additional activities, e.g. reviewing plan, administering influenza vaccine, etc.
  - Journey updated
- Remove – 'begins to walk daily' to shorten
  - Journey updated
- Wording re: 'receiving referrals' updated and moved to Stage 1

CCM Timeline: Stage 2 - Description

Kate the Dietitian works with Caterina to develop a personalised nutrition plan and provides guidance on tracking her food intake. Kate schedules a follow up appointment with Caterina.

Josh the Exercise Physiologist designs an individualised physical activity plan with Caterina.

Amanda the Practice Nurse administers Caterina's yearly influenza vaccination, updates Caterina's care plan and organises a 3-month case conference for all members of Caterina's care team.

Dr Jones reviews Caterina's care plan and notes Caterina's blood glucose levels remain outside target range. Dr Jones adjusts Caterina's current medications, requests updated blood tests and arranges a follow-up visit to monitor progress.

Notes:

Cindy the pharmacist – pt has current meds – late for her to turn up at 3 months ? – potentially add into stage 1??? But may be no need to highlight at this point.

Shorthand could be: Kate(Diet), Josh (ExPhys), Tim (DE), Amanda (RN), Cindy (Pharm), Carol (Optom), Jessica (Pod), James (Psychol) – if need to save space

CCM Timeline: Stage 2

Previous

Patient Empowerment

- Maria tracks her weight and activity in an app, Josh the Exercise Physiologist is able to provide support & encouragement to Maria via the app.

Data and Systems - Immediate

- ServiceRequest received by Dietitian & Exercise Physiologist; Goals, Interventions and Procedures updated.
- Changes to Goals, Interventions and Procedures updates CCMP.
- ePrescribing for medications
- Updates to My Health Record

Data and Systems - Future

- Clinical decision support recommends best practice medication treatment.
- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Update to patient summary

ePrescribing – does not necessarily reflect what the pt is taking at a point in time – would be useful to understand what a pt is taking – is there an opp to capture this in here? Patient entered?
Syncing what is dispensed by pharmacists (though still not a direct representation of what pt is taking

Updated

Patient Empowerment

- Caterina tracks her weight and activity in an app, Josh the Exercise Physiologist is able to provide support & encouragement to Caterina via the app.

Data and Systems - Immediate

- ServiceRequest received by Dietitian & Exercise Physiologist; Goals, Interventions and Procedures updated.
- Changes to Goals, Interventions and Procedures & Food and nutrition summary updates CCMP.
- ePrescribing for medications
- Encounter record information readily accessible & exchangeable to My Health Record

Data and Systems - Future

All members of Caterina's care team can view and update Caterina's CCMP
Clinical decision support recommends best practice medication treatment, relevant diagnostic tests & timeframe to arrange follow-up
Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
Encounter record information readily accessible & exchangeable to update AU patient summary information

Feedback & Changes

Patient Empowerment

- Should app data be included in Data and systems
  - No change made as focus is patient empowerment, not the app.

Data & systems - Immediate

- Added 'Food and nutrition summary' to data being updated in CCMP
- Updated wording
  - 'Encounter record information readily accessible & exchangeable to My Health Record'

Data & systems – Future

- Make data accessible to care team
  - Added 'All members of Caterina's care team can view and update Caterina's CCMP'
- Updated wording
  - 'Clinical decision support recommends best practice medication treatment, **relevant diagnostic tests & timeframe to arrange follow-up'**
- Updated wording
  - 'Encounter record information readily accessible & exchangeable to update AU patient summary information'

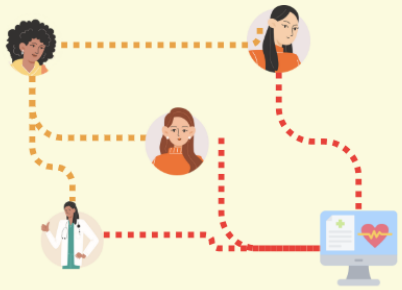
CCM Timeline: Stage 3

Previous

3–6 months

Clinical Review & Escalation

Quarterly Check-In

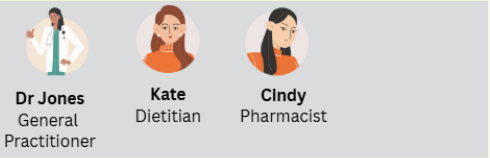


Maria reports fatigue and some confusion around medications.

Dr Jones reviews Maria's lab results, including FBC, HbA1C, lipids, LFTs, & urinary albumin, and liaises with Kate the Dietitian to review Maria's current dietary intake

Kate works with Maria to adjust her current nutritional plan

Maria's pharmacist also provides a Home Medicines Review.



Updated

3–6 months

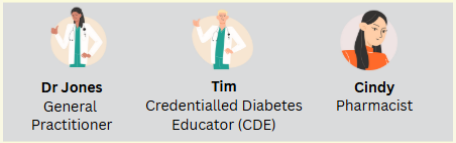
Clinical Review & Escalation

Quarterly Check-In

Caterina presents to Dr Jones with some questions regarding her medications. Caterina reports that she has been experiencing diarrhoea when taking Metformin and has stopped using it.

Dr Jones assesses Caterina, checks her recent lab results and reviews her current list of medications. Dr Jones agrees with ceasing Caterina's Metformin, and also liaises with Tim the Credentialled Diabetes Educator to provide additional support and education to Caterina.

Caterina's pharmacist, Cindy, undertakes a Home Medicines Review, provides additional education to Caterina regarding her current medications and identifies an over-the-counter supplement that Caterina has been taking.



Feedback & Changes

- Update journey story to use example where patient is experiencing medication side-effects, not 'fatigue'
  - Journey updated
- Swap symptom reported from 'fatigue' to 'diarrhoea' related to use of Metformin
  - Updated
- Use 'questions regarding' instead of confusion
  - Updated
- Dr Jones activities more comprehensive/holistic
  - Updated
- Refer to CDE in Stage 3, move Dietitian to Stage 4 instead.
  - Updated
- Make pharmacist activities more comprehensive
  - Updated

CCM Timeline: Stage 3 - Description

Caterina presents to Dr Jones with some questions regarding her medications. Caterina reports that she has been experiencing diarrhoea when taking Metformin and has stopped using it.

Dr Jones assesses Caterina, checks her recent lab results and reviews her current list of medications. Dr Jones agrees with ceasing Caterina's Metformin, and also liaises with Tim the Credentialled Diabetes Educator to provide additional support and education to Caterina.

Caterina's pharmacist, Cindy, undertakes a Home Medicines Review, provides additional education to Caterina regarding her current medications and identifies an over-the-counter supplement that Caterina has been taking.

Notes:

is it realistic to assume that the medication side effect would not have been raised prior to 3 monthly review?

Experiencing mild diarrhoea but has recently stopped using the metformin…

→ Caterina goes to see the Tim

Metformin – should be lower case

CCM Timeline: Stage 3

Previous

Patient Empowerment

- Use of PREMs/PROMs for monitoring of Maria's experience of fatigue, energy levels and wellbeing.

Data and Systems - Immediate

- Recent diagnostic results promptly available .
- Medication Statement updated; follow-up scheduled.
- Changes to MedicationStatement and follow-up update CCMP.
- Updates to My Health Record

Data and Systems - Future

- Clinical decision support recommends medication review when Maria's fatigue is recorded in CCMP
- Data linkage to pharmacist's system & dispensing history for Maria
- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Update to patient summary

Members of care team have Caterina PS info which can be used in her care????

Updated

Patient Empowerment

- Use of PROMs for monitoring of Caterina's health status and wellbeing.

Data and Systems - Immediate

- Recent diagnostic results promptly available .
- Follow-up scheduled.
- Changes to Problem/diagnosis and Medication statement updates CCMP.
- Encounter record information readily accessible & exchangeable to My Health Record

Data and Systems - Future

- All members of Caterina's care team can view and update Caterina's CCMP
- When Caterina's symptoms are recorded in CCMP, clinical decision support recommends medication review, relevant diagnostic tests & timeframe to arrange follow-up.
- Data linkage to pharmacist's system & dispensing history for Caterina.
- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Encounter record information readily accessible & exchangeable to update AU patient summary information

Feedback & Changes

Patient Empowerment

- Remove PREM – doesn't measure fatigue/energy

Data & systems - Immediate

- Added 'Food and nutrition summary' to data being updated in CCMP
- Updated wording
    - 'Encounter record information readily accessible & exchangeable to My Health Record'

Data & systems – Future

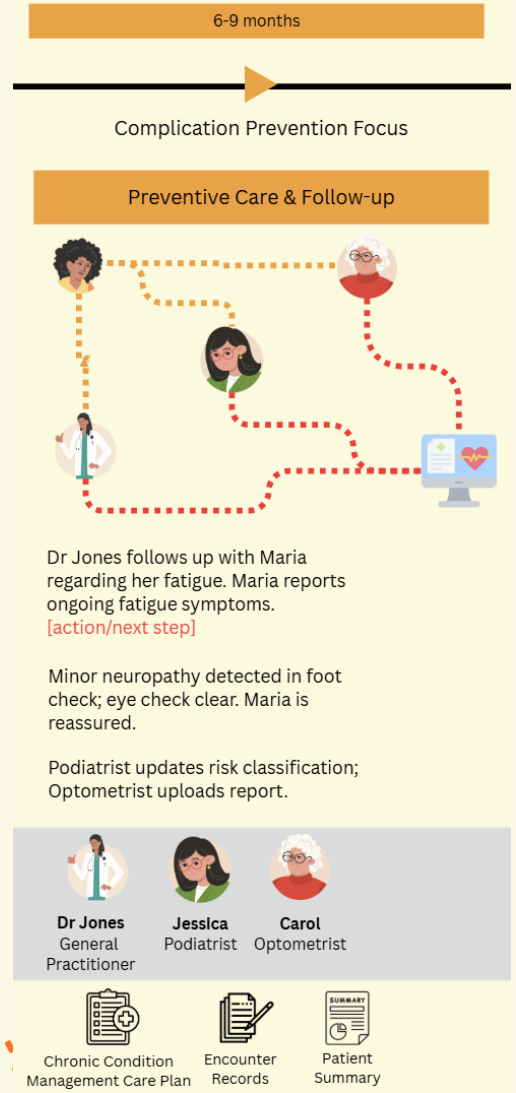
- Make data accessible to care team
    - "All members of Caterina's care team can view and update Caterina's CCMP" added
- Updated wording
    - 'Encounter record information readily accessible & exchangeable to update AU patient summary information'

Hairy qn: where does the responsibility lie to act if the data is available to the GP/clinician? – noting previous RACGP position in past with being pushed dispensing records

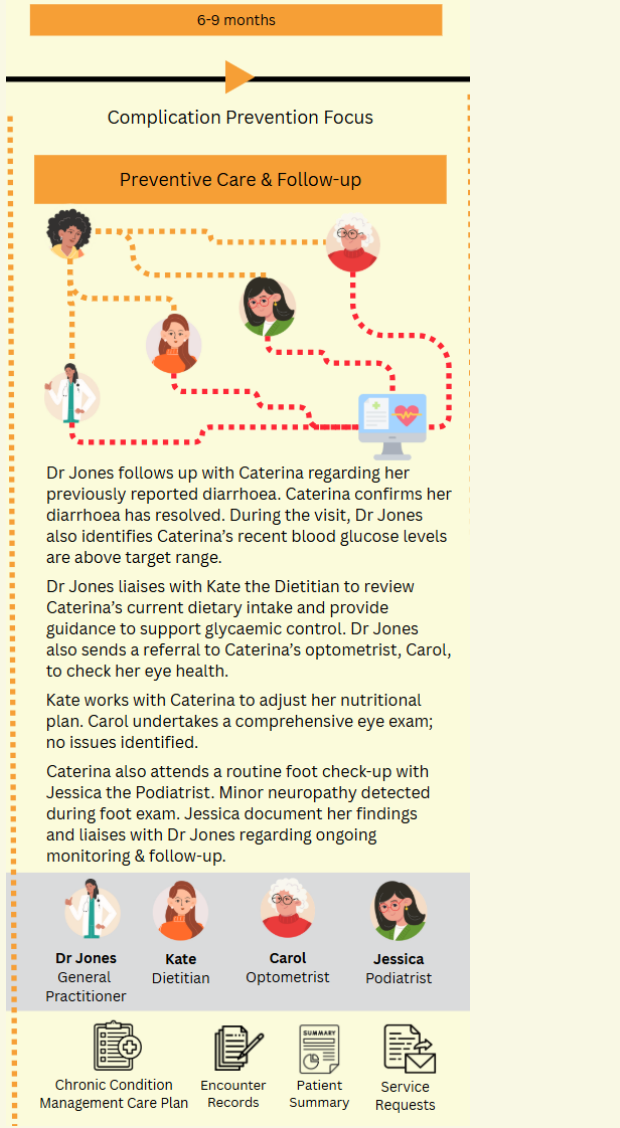
Sparked HL7 FHIR

CCM Timeline: Stage 4

Previous



Updated



Feedback & Changes

- Diarrhoea has resolved
  - Journey updated
- HbA1c increased/worsening blood glucose control as a result of the cessation of the Metformin. Non-pharmacological management is the first focus
  - Journey updated
- Update journey so Stage 3 involves referral to diabetes educator and Stage 4 has a dietitian review.
  - Journey updated
- Expand on activities undertaken by Podiatrist & Optometrist

Question for CFG

- Does Caterina's appt with Jessica the Podiatrists require a referral earlier in the journey/stages?

CCM Timeline: Stage 4 - Description

Dr Jones follows up with Caterina regarding her previously reported diarrhoea. Caterina confirms her diarrhoea has resolved. During the visit, Dr Jones also identifies Caterina's recent blood glucose levels are above target range.

Dr Jones liaises with Kate the Dietitian to review Caterina's current dietary intake and provide guidance to support glycaemic control. Dr Jones also sends a referral to Caterina's optometrist, Carol, to check her eye health.

Kate works with Caterina to adjust her nutritional plan. Carol undertakes a comprehensive eye exam; no issues identified.

Caterina also attends a routine foot check-up with Jessica the Podiatrist. Minor neuropathy detected during foot exam. Jessica document her findings and liaises with Dr Jones regarding ongoing monitoring & follow-up.

Notes:

Include both HbA1c and blood glucose levels

Dr jones follows u with Caterina's diabetes control and confirms that the diarrhoea has resolved…

Check RACGP guidelines – should opto be referred right at the beginning? (often when first diagnosed, presence of retinopathy)

Refer to podiatrist

Funding reasons - often means a lot allied health referrals happens up front (expt opto – since medicare funding so no formal referral not required – unless GP wants a letter!)

GP – more focus on preventative at this pt? vaccines, screening,

CCM Timeline: Stage 4

Previous

Patient Empowerment

- Maria updates her Goals of care and accesses a current care summary

Data and Systems - Immediate

- Observations (foot risk, visual status) recorded
- Foot and eye screening data captured and shared promptly.
- Updates to My Health Record

Data and Systems - Future

- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Update to patient summary

Updated

Patient Empowerment

- Caterina updates her goals of care and accesses a current care summary

Data and Systems - Immediate

- Changes to Food and nutrition summary and Follow-up updates CCMP.
- Observations (foot risk, visual status) recorded
- Foot and eye screening data captured and shared promptly.
- Encounter record information readily accessible & exchangeable to My Health Record

Data and Systems - Future

- All members of Caterina's care team can view and update Caterina's CCMP
- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Encounter record information readily accessible & exchangeable to update AU patient summary information

Feedback & Changes

Patient empowerment

- No change

Data and Systems – Immediate

- Aligned to journey activities undertaken – additional changes required?

Data and Systems – Future

- Aligned to changes in previous stages – additional changes required?

Sparked HL7 FHIR

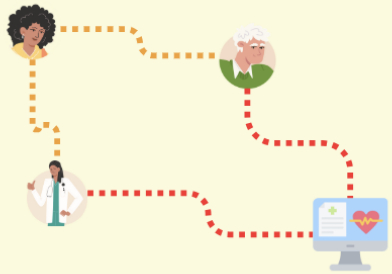
CCM Timeline: Stage 5

Previous

9-12 months

Annual Wellbeing Review

Annual Review & Future Planning (12 months)



Maria reflects on her progress. Mild emotional distress discussed.

Dr Jones reviews the full cycle; refers to psychologist; renews CarePlan.

Dr Jones General Practitioner

James Psychologist



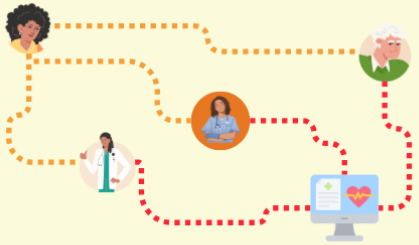
Chronic Condition Management Care Plan | Encounter Records | Patient Summary

Updated

9-12 months

Wellbeing Review

Emotional Wellbeing Support (12 months)



At Caterina's next appointment, Dr Jones observes a shift in her emotional state and reviews Caterina's recent PROMs results. Caterina's son also expresses concern about recent changes in her behaviour. Caterina shares that she has been feeling overwhelmed, stressed, and is finding it difficult to cope with the demands of managing her condition.

Amanda the Practice Nurse and Dr Jones work closely together to arrange regular check-ins that include Caterina's son and husband, to monitor Caterina's emotional wellbeing and ensure her support network remains actively involved in her care.

Dr Jones also refers Caterina to James, the Psychologist. Together, James and Caterina explore her current emotional state, to develop coping strategies and manage the impact of her chronic condition.

Caterina reflects on her progress and experience over the past year




Dr Jones General Practitioner | **Enzo** Caterina's son | **Amanda** Practice Nurse | **James** Psychologist




Chronic Condition Management Care Plan | Encounter Records | Patient Summary | Service Requests

Feedback & Changes

- Make patient's distress more acute.
- Incorporate use of PROMs information
- Include patient's son/family/support network into journey
  - Journey update for above changes

- Unlikely to do an 'annual' case conference unless a specific issue requires it

CCM Timeline: Stage 5 - Description

At Caterina's next appointment, Dr Jones observes a shift in her emotional state and reviews Caterina's recent PROMs results. Caterina's son also expresses concern about recent changes in her behaviour. Caterina shares that she has been feeling overwhelmed, stressed, and is finding it difficult to cope with the demands of managing her condition.

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Caterina reflects on her progress and experience over the past year

Notes:

Change to Enzo to George? One or the other – no need for both (align images)

Referral to psychologist – more likely to be part of a mental health plan, also a challenge for pt to afford the gap fees. Alternatives – community support services, non-clinical psychologists….

- Mention mental health care plan kicked off? (and note opportunity of data from ccmp can inform the mental health plan)

Last sentence - Fitting in with her other life commitments (working, caring for grandchildren/other people in family, etc.)

CCM Timeline: Stage 5

Previous

Patient Empowerment

- [Patient empowerment opportunity]

Data and Systems - Immediate

- Structured, multi-disciplinary care contributes to quality improvement datasets.
- Updates to My Health Record

Data and Systems - Future

- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Update to patient summary

Updated

Patient Empowerment

- Ongoing use of PROMs monitors Caterina's wellbeing over time, and enables Caterina's care team to tailor their approaches to her specific needs and preferences.

Data and Systems - Immediate

- Structured, multi-disciplinary care contributes to quality improvement datasets.
- Encounter record information readily accessible & exchangeable to My Health Record

Data and Systems - Future

- All members of Caterina's care team can view and update Caterina's CCMP
- System trends PROMs data over time and Clinical Decision Support recommends best practice interventions or follow-up to relevant care team member(s) as required.
- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Encounter record information readily accessible & exchangeable to update AU patient summary information

Feedback & Changes

Patient empowerment

- PROMs information review, used and/or actioned.

Data and Systems – Immediate

- Aligned to journey activities undertaken – additional changes required?

Data and Systems – Future

- Added opportunity for PROMs information to be used to enable Clinical Decision Support
- Aligned to changes in previous stages – additional changes required?

Reuse of info across care plans

this may be outside scope of the project, but a consumer-focused opportunity could be using decision support tools to suggest ways to engage in healthy behaviours

e.g. some corporate / private health insurance companies have apps that include articles about health topics, or actions like step goals / trends, etc

Sparked HL7 FHIR

Broader questions or issues for external discussion "Hairy questions"

Meeting 2:

- Data responsibility – **who owns or manages the data** recorded through wearable/home devices used for health purposes (i.e. IoT food diary/smart fridge example)?

- **Need to define - who is accountable for acting on test results in the following scenario?**
  - i.e. the clinician who orders a test is currently considered responsible for managing the result however improved data accessibility (e.g. via MyHR) means the patient may be notified of critical results even before their healthcare provider sees them.

Meeting 3:

- Can a **consumer update their own CCM/PS** – to correct, to add new, to update? If yes – how is this managed, what are the implications of this, how do we show the provenance of this change?

Meeting 4..?

Hairy qn: where does the responsibility lie to act if the data is available to the GP/clinician? – noting previous RACGP position in past with being pushed dispensing records

Workshop activity 2: Chronic Condition Management Journey Wheels

Consumer Journey

1. Visit GP

Assessment

2. Visit Pathologist

Diagnosis Chronic Condition

3. Return to GP

Management & Care Coordination

4. Day Surgery

Interventions

5. Post-Op Review

Monitoring

6. Return to GP

Evaluation & Review

7. Visit Pharmacy

8. Prevention & Maintenance

Individual

Allied Health Journey

Another Journey

Another Journey

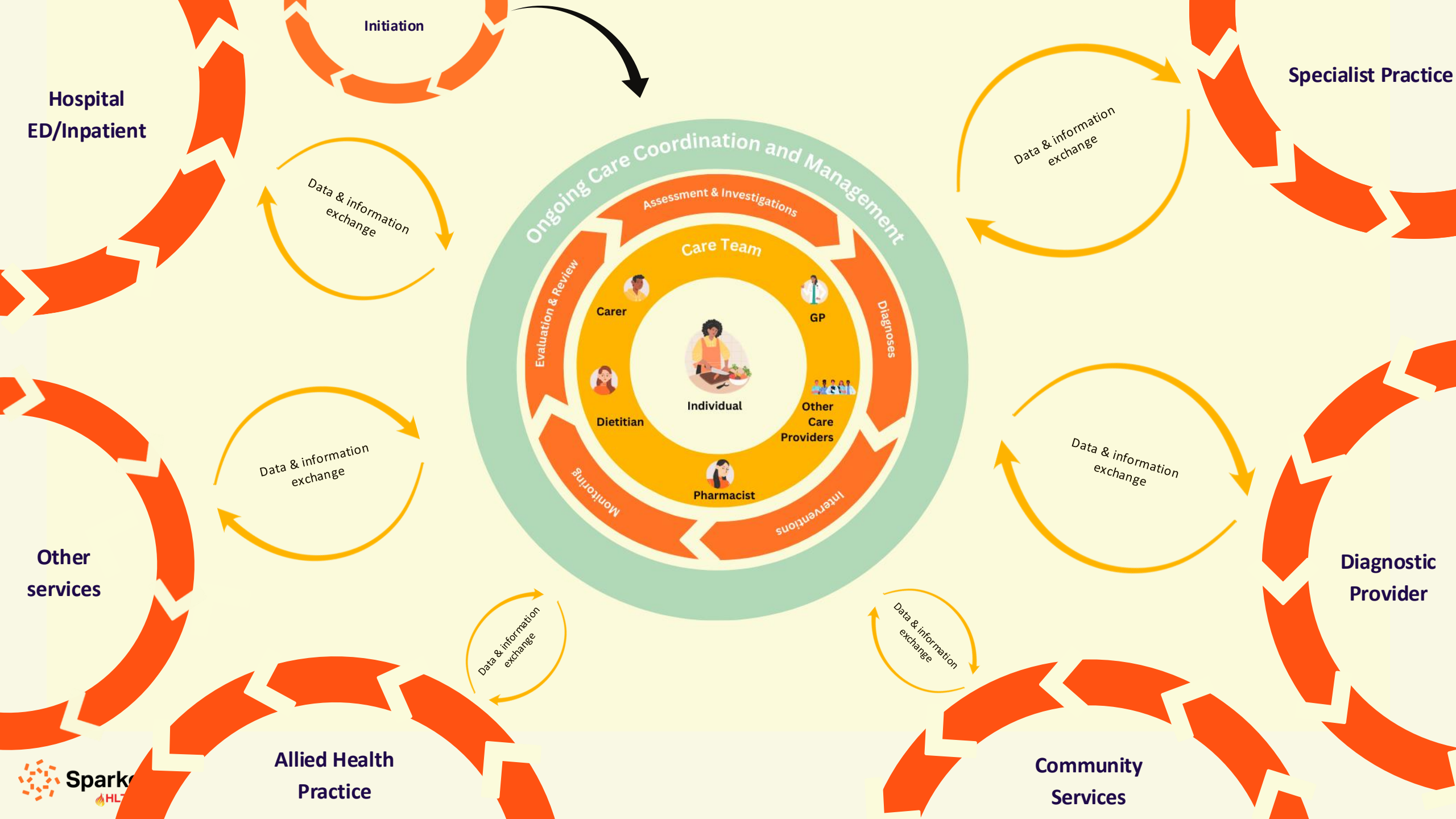
Another Journey

Another Journey

Pathology Laboratory Journey

Hospital Journey

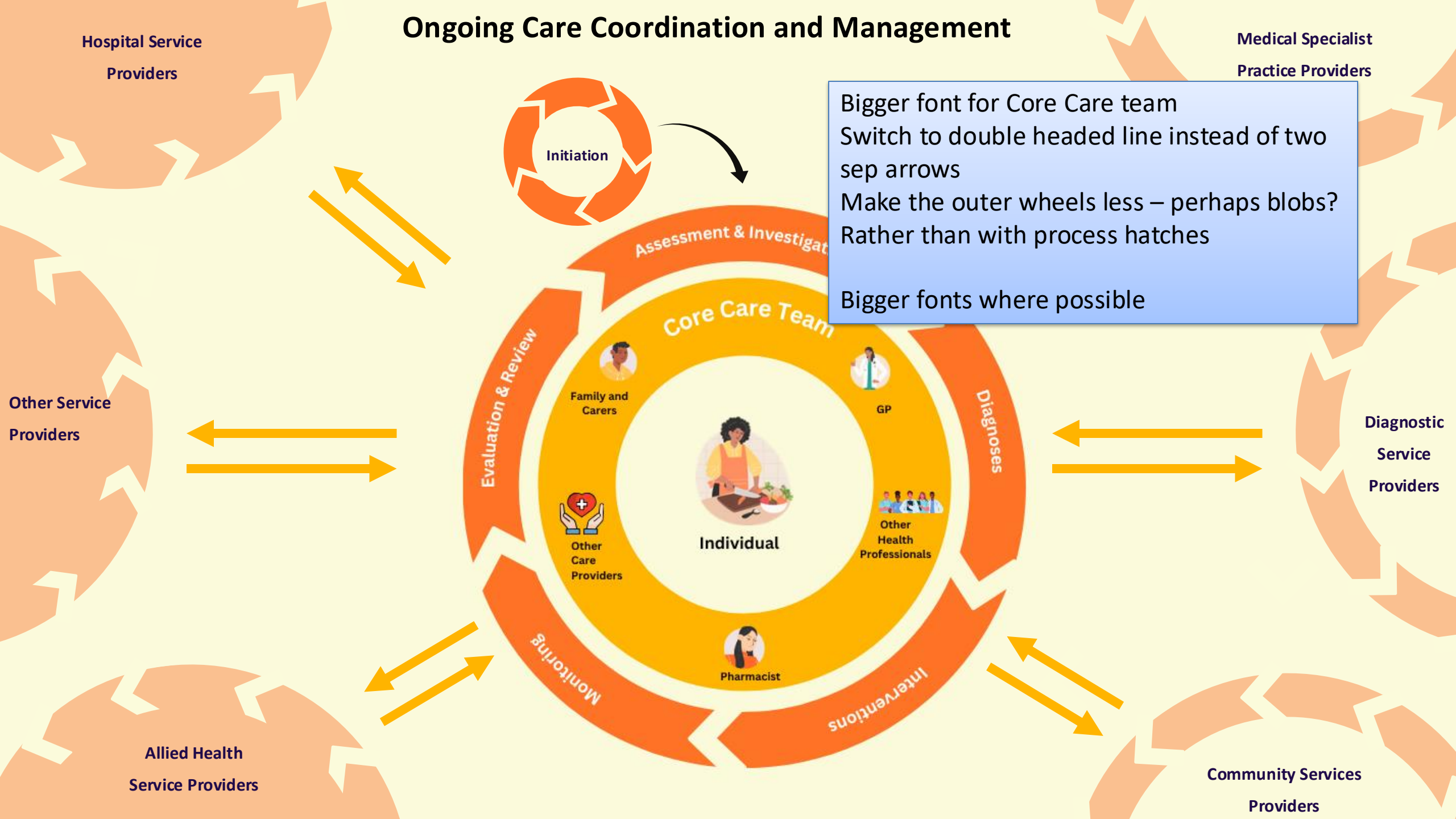
GP Journey


Initiation
Hospital
ED/Inpatient
Specialist Practice
Data & information exchange
Data & information exchange
Ongoing Care Coordination and Management
Assessment & Investigations
Diagnoses
Interventions
Monitoring
Evaluation & Review
Care Team
Carer
GP
Dietitian
Individual
Other Care Providers
Pharmacist
Data & information exchange
Data & information exchange
Other services
Diagnostic Provider
Data & information exchange
Data & information exchange
Allied Health Practice
Community Services

Feedback & Changes

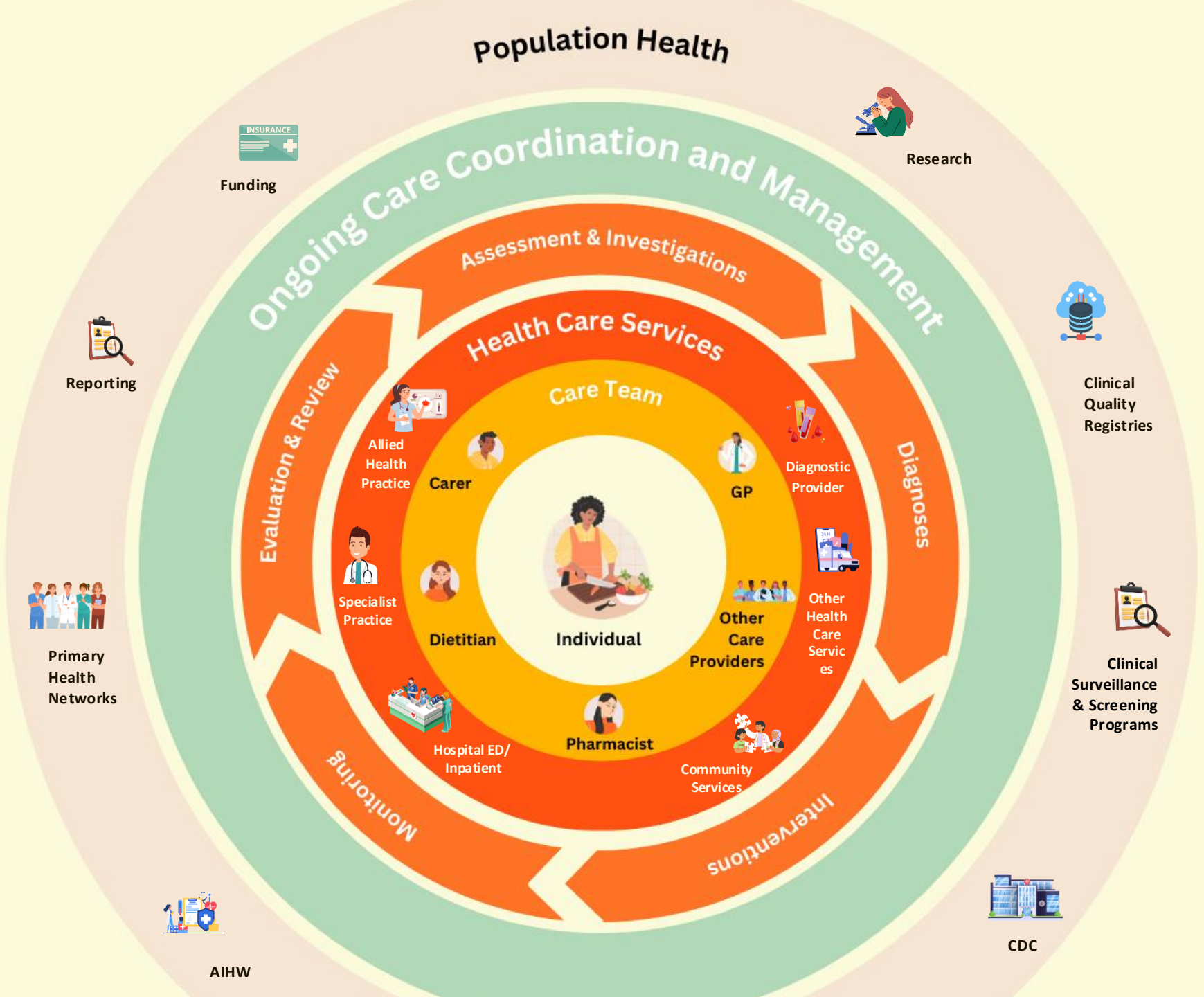
- Need to make sure we include dentists in this universe
  - Included under other providers
- Change “Specialists” to “Medical specialists”
- Lift care team to be more generic, i.e.
  - GP
  - Family and carers
  - Other care providers
  - Other health professionals and organisations – used ‘Other health professionals’
  - Pharmacist
- Make individual wheel bigger
- Outer wheels
  - Consider using icons instead, we’ve left them as is for clarity currently
  - Options: Change/add icons, filled in (left) rings only (right).
- Remove words ‘data & information exchange’
  - Updated

Ongoing Care Coordination and Management



Bigger font for Core Care team
Switch to double headed line instead of two sep arrows
Make the outer wheels less – perhaps blobs?
Rather than with process hatches

Bigger fonts where possible

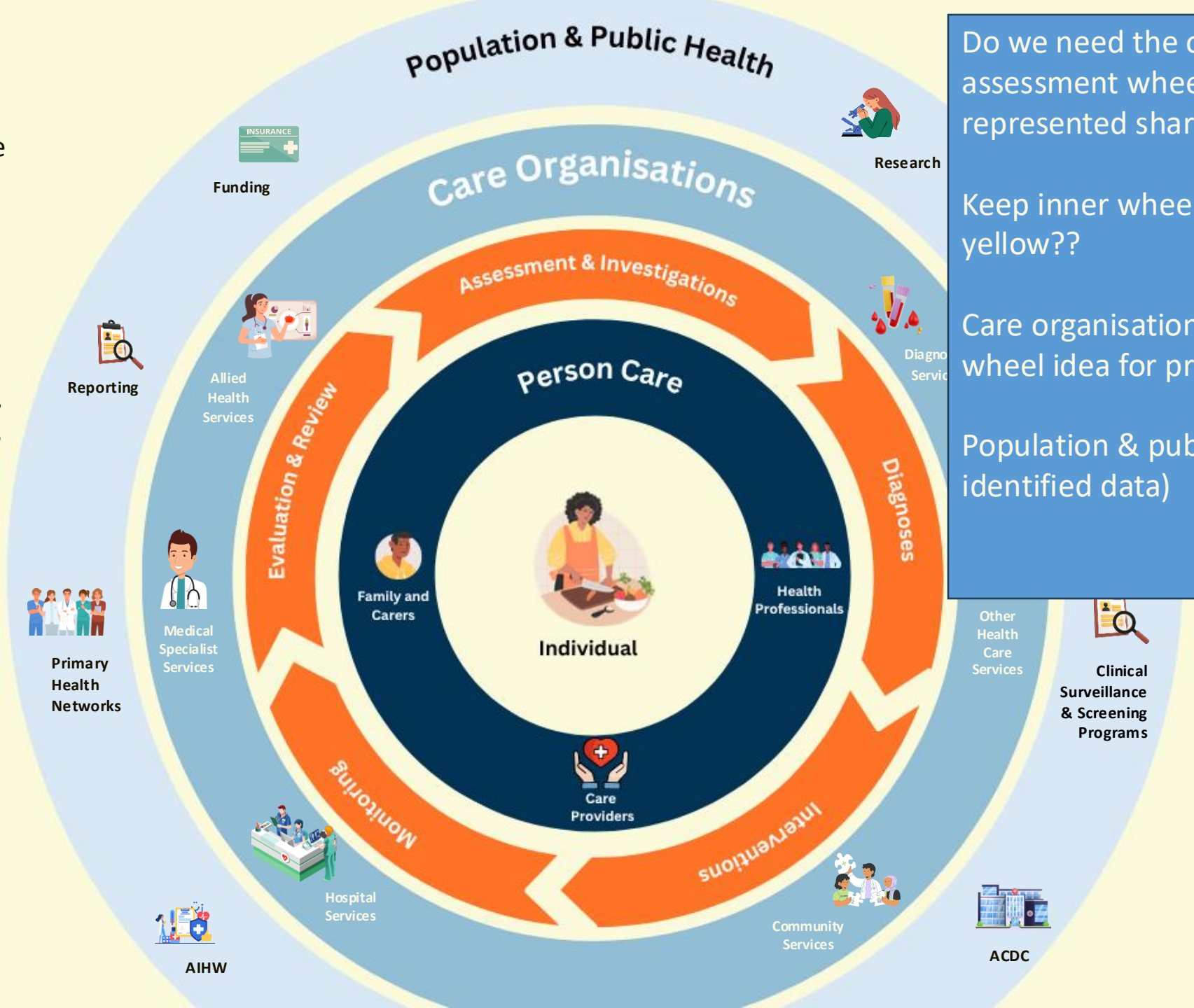

Population Health
Ongoing Care Coordination and Management
Assessment & Investigations
Diagnoses
Interventions
Monitoring
Evaluation & Review
Health Care Services
Care Team
Individual
Carer
Allied Health Practice
GP
Diagnostic Provider
Specialist Practice
Dietitian
Other Care Providers
Other Health Care Services
Hospital ED/ Inpatient
Pharmacist
Community Services
Funding
Research
Reporting
Clinical Quality Registries
Primary Health Networks
Clinical Surveillance & Screening Programs
AIHW
CDC

Feedback & Changes

- Remove ‘Ongoing care coordination and management’ ring
- Focus on population health – simplify the internal rings
  - Reduce messiness
  - Consider if population health should be represented as a parallel path
- Clarify purpose of diagram

Primary to population

The purpose of this diagram is to demonstrate the levels at which healthcare information documented during a patient's journey may be collected, exchanged and used at multiple levels to support various purposes, professions, organisations and use cases.
Visualising this eco-system allows us to practically understand and consider what is required to support an interoperable and learning healthcare system in Australia



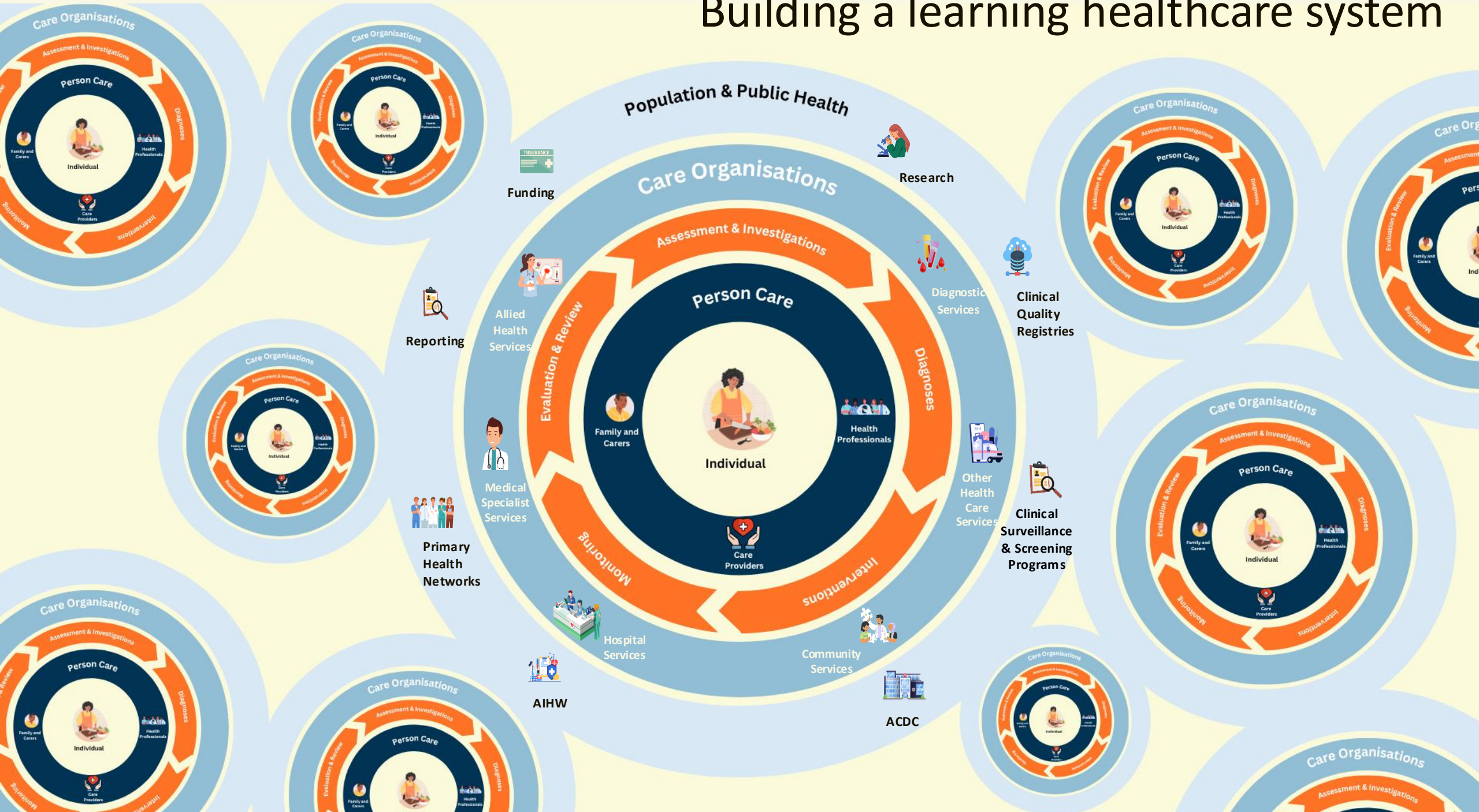
Do we need the orange assessment wheel? – but does it represented shared information

Keep inner wheel colour – yellow??

Care organisations – use this wheel idea for process diagram

Population & public health (de-identified data)

Building a learning healthcare system



Any additional artefacts/materials required for CCM?

Next Meetings - TBD

Future meetings to be determined based on July CDG & F2F workshop outcomes

If you can come to July CDG – please do!!

We will be focussing on the processes and workflows associated with Chronic Condition Mgmt, as well as AU Patient Summary

Eventbrite tickets will be coming out this afternoon 4pm

Upcoming Events 2025

July 2025

- **29th & 30th in Sydney** – CDG and Sparked face to face meeting

August 2025

- **27th–** CDG (online)

September 2025

- **1st & 2nd in Brisbane** – HL7 AU Connectathon
- **17th** – CDG (online)

October 2025

- **8th** – CDG (online)

Sparked HL7 FHIR

For additional info regarding upcoming Sparked events, please check out the https://sparked.csiro.au/ website

Thank you!!