Minutes – Chronic Condition Management Clinical Focus Group Online Meeting 2

Meeting Details	
Date	2 May 2025
Time	3:00 pm – 5:00pm AEST
Location	☒ Virtual

Meeting Overview	
Agenda Items	1. Acknowledgement of country 2. Welcome 3. Scope of the Chronic Condition Management Clinical Focus Group 4. Workshop activity 1: Chronic Condition Management Journey Wheels 5. Workshop activity 2: Detailed CCM Journey timeline 6. Future meetings and upcoming meetings

Discussion Summary	
Welcome	Welcome • Acknowledgement of Country • Agenda presentation
Scope of the Chronic Condition Management Clinical Focus Group	*Purpose* • The Sparked Chronic Condition Management Clinical Focus Group (CCM CFG) is a sub-group of the Sparked CDG • It is a time-limited committee, subject to the Sparked program requirements • It aims to provide targeted clinical support to enable the development of Chronic condition management priorities within Sparked • See slide pack for extended CCM CFG Scope details • AUCDI Data Groups, FHIR implementation guides, and broader policy discussions are out of scope for the CCM CFG *Previous meeting feedback summary* • Consumer or individual-centred approach • Represent the asynchronous/circular aspects of CCM; whilst still demonstrating realistic chronological examples

	• Demonstrate variability in management of chronic conditions, consider co-morbidities
	• Shared, dynamic, flexible care plans
	• Support ongoing updates and visibility to all care team members, including the consumer
	• Expand the care team composition to show diversity of care providers, including family & informal carers
	• Incorporate patient goals and clinical priorities
	
	Proposed Approach: 2 diagrams
	• High-level, multiple flows/journey
	  ○ Proposing a high-level way to demonstrate different phases that occur in a patients experience of chronic condition management
	  ○ Helps to illustrate the nuance and complexity of chronic condition management – it isn't always linear
	• Detailed 'timeline' based example
	  ○ Aims to be a secondary, more detailed chronological view of the patient's experience of chronic condition management

Workshop 1 Activity: Chronic Condition Management Journey Wheels	*Journey Wheels*
	• The journey wheel is structured to have the patient in the centre, followed by the central journey wheel around the individual; the orange arrows showcasing the high-level phases of the consumer journey and the respective steps (e.g. visit GP) that may be occurring for the patient during those phases situated outside the inner 'wheel'
	• Surrounding this central wheel, there may be additional pathways (displayed as additional wheels) occurring at the same time
	  ○ This example includes consumer, allied health, GP, hospital, pathology laboratory – are these the example wheels we want to demonstrate on this diagram? Are there others to include or existing ones to exclude?
	• Further discussion needed to determine how to animate this information to showcase bridges, linkages, interactions and fluidity within the journeys – currently this diagram is quite static
	
	Group Discussion – Journey Wheels
	• The diagnosis element of the internal orange wheel could be removed to sit as a separate element to the centric patient wheel, as the additional elements such as assessment, interventions, monitoring etc will be ongoing however diagnosis of a specific issue typically only occurs once
	  ○ The caveat is that not all diagnostic journeys are simple and straight forward, and misdiagnosis can occur

- A patient may have a key care team and additional care team members come into their journey with their relevant expertise, as needed – this may be better represented as concentric growing circles rather than different circles themselves
- Diagnostics could be represented through an arrow which spins off the main patient journey into a smaller, diagnostic based wheel, which may have some overlap with other elements of the journey (e.g. pathology, day surgery for biopsies), and then spin back to re-integrate into the main patient journey
- Additional bubbles may be needed, including nursing, public population research, and private specialist
- Each journey wheel needs to have a purpose and a result, and it would be easier to understand if there is a commonality in the components of the wheel whilst also maintaining the nuance and differences in the patient journey of the particular specialty area
- Another suggestion for visual depiction of the journey is a patient journey maze, to represent the complexity of a patient journey and to highlight that it is not always straight forward and simple
- Need to determine how to best represent the patient journey – is this through utilising settings (hospital), professions (GP, allied health) or a combination of both?
- Consider whether day surgery is the best terminology – this procedure may not be surgery but instead a procedure – e.g. dialysis
- The nominated practitioner should always have access to information regardless of which patient wheel the information is occurring within
- Using a cogs in a wheel approach, a patient may have a primary clinician that they see and who oversees their care (the main cog in the machine) and over time as their needs change, other clinicians may be drawn in and control of the patients care is handed over to them (thus making them the main cog and making their long-term clinician a smaller cog in the system), before the patient returns to their long-term clinician for continuity of care, as their main practitioner again
- Many patients who have chronic conditions have multiple conditions and require complex healthcare – this may become difficult to represent within journey wheels

Group discussion – key journey wheels to include within a chronic condition management plan

- Chronic conditions can be surfaced through screening programs or alternative methods so incorporation of a public screening wheel could include this in the diagnostic/initiation of care process

- Funding is an important factor in care and its accessibility to patients
- There is currently a transition to a different database for screening programs and registries for disease, and this database should be linked to

Phases within the journey wheels (inner wheel)

- Aim to receive group feedback on the current consumer phases across the journey wheel
- Current phases include: assessment, diagnose chronic condition, management/care coordination, interventions, monitoring, evaluation and review

Group feedback:

- There may not be a diagnosis of a chronic condition but instead identification of symptoms
- There may not be a formal assessment, as many patients will present with symptoms/discomfort initially
- The chronic condition management journey can commence in a multitude of ways including through raising a health concern, through signs and symptoms (even if the patient is not concerned by these), through screening programs or testing, or through observation – this could be represented through a 'encounter/presentation' consumer journey phase prior to the assessment phase
- Diagnosis can be a backwards and forwards process that develops over time and consequently, it may be clearer to withdraw diagnostics into a separate smaller journey wheel which sits outside of the inner journey wheel, and the inner journey wheel reflecting ongoing chronic condition management
- The purpose of the wheel may not be to show where the patient enters but rather to highlight that the patient does not leave the chronic condition management cycle
- Chronic condition management is multi-dimensional, and the patient may transition between journey wheels during their care as different services engage and disengage based on the patient's needs and which condition is being actively managed - ensure engagement with all input/output points is considered
- A patient may present with an issue (e.g. shoulder pain) which the clinician will treat and manage and may include other clinicians in the care team based on a preliminary assessment (e.g. physiotherapist) however, formal diagnostics may not occur until after management has already commenced
    - This journey may look like: Assessment > Management > Care Coordination > Assessment > Assessment

	• We want to ensure that we don't create additional burden, for a patient with multiple morbidities, to specify which of the patient's conditions is the primary reason for engagement – aim to avoid additional explanatory work regarding each condition and how it relates to each individual wheel • Potential to consolidate the evaluation and assessment sections together • Addition of an internal continuous wheel which holds ongoing chronic condition management, as this occurs at all phases of the journey wheel and faded stacks behind the inner wheel which can represent co-morbidities, if relevant to the patient *Steps within the journey – (outer wheel)* • Aim to receive feedback on whether these steps are reflective of a common CCM consumer journey? • Current steps include: Visit GP, Visit Pathologist, Return to GP, Day surgery, Post op review, Return to GP, Visit pharmacy, Prevention and maintenance *Group Feedback:* • The current wording may be too mechanical and specific for the complexity of a consumer journey and instead should focus on generic goals – e.g. the step 'visit pathologist' aims to be investigative based on a clinician's request following a patient consultation • Demonstrate the steps in how they bridge to the inner wheel • Consider the addition of avatars in the inner wheel to represent personnel and place of care • When utilising the journey wheel we shift from specific steps of the journey, instead focusing on the phases of the journey, as the secondary diagram showcases the chronological journey • Access to healthcare services and funding can be dependent on criteria (patient entitlement, referrers, provider of the service) and consequently, entry into the journey wheel may have some pre-requirements – this part of the wheel needs to be linked for both clinical care and reimbursement • The preliminary patient journey wheel can built and layered with additional elements like referrals, data flows, and funding rules which can help to guide development of future best practices and funding models
Workshop Activity 2: Detailed CCM Journey Timeline	*Timeline based, linear patient journey* • See slide pack and Sparked website for diagram • The diagram aims to capture some of the stages that a patient may go through within a 12-month period

- The example shown includes Maria's patient journey, previously discussed in the CCM CFG, and her type 2 diabetes chronic condition management
- The activities in Maria's timeline are broken into 5 phases – see slide pack for full detail
- The diagram includes different stages of Maria's health journey and the high-level activities associated with each stage, accompanied by a description and the different opportunities for each stage, and a call-out to some of the data and systems activities

Group feedback

- Risk/complication prevention is typically addressed sooner than the 9 months listed in the timeline diagram
- Education is not a once-off activity, and will be ongoing throughout their health journey

Stage 1 – Diagnosis of Type 2 Diabetes – see slide pack for full detail

- Maria is overwhelmed by her diagnosis but grateful for an explanation of her symptoms, her GP explains the diagnosis and refers her to specialists, and she meets with a credentialed diabetes educator and learns how to monitor her glucose
- Opportunities associated include: shared care visibility and the data and systems include creation of condition, CarePlan, and service request resources, updates to My Health Record

Group Feedback

- As discussed in the previous meeting, it is unlikely that a patient with type 2 diabetes would be initially referred to a specialist however, even if the GP and credentialed diabetes educator (CDE) in the same clinic, Maria would receive a referral to a CDE (potentially an internal referral)
- The CDE will provide more information and education than what is listed in the example, including dietary education, and will be ongoing
- Consider potential update to wording around the consultation with the CDE, as this can often occur in-practice with a registered practice nurse
- Include timeframe as an additional heading to allow for ongoing treatment options (e.g. education is ongoing and will not be constrained to 0-1 months)
- Include a support person for Maria, in this example her son or daughter
- There is an opportunity for consumers and for reuse of data as data is populated and shared from existing systems – aiming to decrease duplication

- Update some of the wording to reflect plain English – currently written as though it would be in a technical setting
- There is an opportunity for Maria to view and update her care plan in addition to contributing to her goals, and for clinicians to receive alerts based on the existing guidelines for care when a patient is newly diagnosed with T2D

Stage 2 – First Treatment Plan Established – see slide pack for full detail

- Kate the dietitian creates a nutrition plan and teaches Maria how to track her food, Josh the exercise physiologist creates an activity plan and Maria starts daily walking, and Maria's GP prescribes her medication
- The opportunities currently associated with this section include patient empowerment, where Maria can track her blood glucose levels and activity in an app and can access a care summary
- The data and systems currently associated with this include a service request which is shared to the exercise physiologist, and goal and procedure records are updated

General Group feedback

- Determine how to represent new care team members both joining and disengaging from the patient journey at it's different phases, in addition to who is involved at each point
    - Potential to add a section along the top of the CCM consumer journey timeline diagram with personas to help identify who is involved at each of the stages
- Icons/personas can be added when utilising concentric wheels to represent what members of the care team are involved at what phase and the engagement/disengagement of additional care team members as necessary
- Communication between dietitian, exercise physiologist, and allied health practitioner back to GP may offer a case conferencing option and may offer multiple reporting back opportunities over the year
- Pharmacist needs to be added as part of the care team, as Maria is prescribed medication, and it needs to be dispensed with education on the medication from the pharmacist
- Determine how to capture consumers with different severities - e.g. consumer who can start with lifestyle/diet vs consumer who needs medication in early stages

Stage 2 Opportunities Group Feedback

- Additional data systems to specify include generating a prescription and updating medication statements
- To achieve patient empowerment, patients need to be taught by a member of their care team and it can be a time-consuming

undertaking to upskill a patient to the point of feeling confident – e.g. tracking glucose, changes to their diet
- The addition of wireless/Bluetooth connectivity for apps to allow for integration
- Patient may need support and help when tracking things that are outside of the normal – how will this be included in the journey?
- Potential for remote specialist monitoring – this occurs in remote cardiology contexts however this may extend to blood glucose monitoring
- There is potential to gain insights from the patient's health data being uploaded either manually or automatically, and for the patient to be empowered with the skillset to understand and interpret what they're seeing within their data
- For a newly diagnosed T2D patient, hypoglycaemic episodes would be uncommon however, tracking hypos could be included in the wording in the patient journey
- The clinician who orders a test is currently considered responsible for managing the result however, MHR supports data accessibility to the patient and patients may be notified of critical results even before their healthcare provider sees them – it's important to define who is accountable for acting on these test results
- Suggested to add weight reduction as an element, as dietary adjustment and additional exercise both work together to achieve reduced weight

Stage 3 – Early Review – see slide pack for full detail
- Maria reports fatigue and confusion around medications, Maria's GP refers her to an endocrinologist and Maria's pharmacist provides a Home Medicines Review
- The opportunities highlighted in this section include alert driven care where trigger-based prompts recommend medication review after fatigue is reported
- The data and systems use highlighted at this stage is the referral to a specialist, in this case an endocrinologist, and an update to the medication and care plan
- The opportunities associated with this stage include alert driven care – trigger-based prompts recommend medication review after fatigue flagged and the potential to use an app to assist with the medication confusion

Group discussion
- The patient may have their biochemistry, including HbA1c, and other factors reviewed by their clinician to determine a source of the fatigue however, it may be premature at this stage to refer to an endocrinologist

    - Should these test results come back and show deterioration of the patient's condition rather than improvement, care can be escalated to a specialist
- Review other care plan aspects such as dietary intake, exercise, observations around weight, BMI, and BP at this stage
- As the patient notes confusion around their medications, a member of the care team such as the GP or practice nurse would identify and unpack the confusion and plan to mitigate the patient's confusion
- Update wording from 'alert-driven care' to 'clinical decision support', as the implication is currently that the alerts determine the care provided
- Update wording to 'best practise advisory alert prompts…'
- The prompts are provided through automated systems using data with parameters
- There is an opportunity for linkage through to the pharmacist and the dispensing history in addition to the pharmacist's knowledge about the patient's medication usage and understanding
- It is assumed that Maria's reporting of fatigue and medication confusion has been documented in the system and has consequently prompted an alert
- There is potential to utilise PREMS/PROMS to track patient fatigue and energy levels

Stage 4 – Complication Prevention Focus

- A minor neuropathy is detected in Maria's foot check and her eye check is clear, the podiatrist updates risk classification and the optometrist uploads the report
- The opportunities at this stage are highlighted as foot and eye screening data is captured and shared promptly
- The data and systems use highlighted at this stage include the observations around the foot (risk, visual status) and a follow-up scheduled in CarePlan

Group feedback

- This description where the podiatrist and optometrist see the patient is not considered to be real-time health monitoring
- Renal function and assessment for Microlabuminuria needs to be done by the 3-month mark

Stage 5 – Annual Cycle of Care Completed – see slide pack for full detail

- Maria reflects on her progress and mild emotional distress is discussed, GP reviews the full cycle, refers Maria to a psychologist and renews CarePlan

	• Opportunities at this stage have been identified as system wide learning - Structured, multi-disciplinary care contributes to quality improvement datasets • Data and systems use at this stage is identified as the bundle of observation results and an updated CarePlan *Who's involved* • Currently involved is Maria, Maria's husband, Maria's GP, a CDE, a dietitian, an exercise physiologist, an endocrinologist, a pharmacist, an optometrist, a podiatrist, and a psychologist • The endocrinologist may be removed at this time • Additional roles called out during the discussion, including a practice nurse, to be updated
Upcoming Meetings and Events	*Upcoming Meetings* • CCM CFG Meeting 3 – 1pm – 3pm AEST 21 May 2025 • CCM CFG Meeting 4 – 11am – 1pm AEST 3 June 2024 *Upcoming Events* • Sparked Partners Online Symposium – 9am – 4:45pm AEST 28 May 2025 • CDG & TDG face-to-face meeting – 29 & 30 July, Sydney ○ Tickets will be released soon • For additional info regarding upcoming Sparked events, please check out the Sparked website

Decisions

ID	Description	Status	Comments
20250502-1D	Update wording from 'alert-driven care' to 'clinical decision support' in stage 3 of the timeline journey diagram	Agreed	
20250502-2D	Update wording to 'best practise advisory alert prompts…' in stage 3 of the timeline journey diagram	Agreed	

Actions

ID	Description	Responsible	Due	Status
20250502-1	• Reach out to the Sparked team with any additional key steps, interactions or gaps in the example journey we should include? ○ Additional information about Maria's background	CCM CFG Members	21/5/25	

	○ Additional healthcare provider interactions ○ Other health information exchange touchpoints or dataflows that need to be called out ○ Other opportunities or system interactions we want to identify?			

Attendees	
1. Tor Bendle	2. Jai Dacey
3. Kylynn Loi	4. Nyree Taylor
5. Adrian Gilliland	6. Averil Tam
7. Cath Koetz	8. Eric Au
9. Heather Leslie	10. Janney Wale
11. Jodie Sheraton	12. Josielli Comachio
13. Oliver Frank	14. Sarah Pearson
15. Sophie Tran	16. Troy Burgess
17. Kenneth Sikaris	18. Kath Feely
19. Nicola Mountford	20. Kim Drever
21. Olivia Carter	22. Kate Ebrill
23. Liz Keen	

Apologies	
1. Stephanie Davis	2. Anthony David Sangster
3. Charlotte Hespe	4. Chris Boyd-Skinner
5. Dr Fabrina Hossain	6. Harry Iles-Mann
7. Melanie Smith	8. Shannon Wallis
9. William Smith	