Minutes – Chronic Condition Management Clinical Focus Group Online Meeting 3

Meeting Details	
Date	21 May 2025
Time	3:00pm – 5:00pm AEST
Location	☒ Virtual ☐ In person

Meeting Overview	
Agenda Items	1. Welcome & general updates a. CCM CFG webpage live b. Meeting materials 2. Workshop activity 1: Chronic Condition Management Journey Wheels 3. Workshop activity 2: Detailed CCM Journey Timeline 4. Future meetings & upcoming events

Discussion Summary	
Welcome and Introduction	*Welcome and Acknowledgement of Country* *CCM CFG Scope* • The focus of the CCM CFG is chronic condition in the context of Sparked and in regard to the user scenarios, data flow challenges and opportunities for interoperable health information exchange
General Updates	*Sparked Website* • There is now a Chronic Condition Management Clinical Focus Group webpage on the Sparked website where you can find meeting materials and further information *Meeting 1* • During meeting 1 a single consumer journey for CCM was proposed *Meeting 2* • Meeting 2 discussed a high-level multiple flows journey and a detailed timeline-based example • The group discussed the idea of chronic condition management wheels and how it relates to the CCM journey • Group discussed and feedback was received on the phases of care and the consumer journey wheels – see slide pack for full detail *Meeting 3* • Proposal for three artefacts for CCM

Workshop 1	*Consumer Journey Wheel 1 – Multiple Wheel Display*
	• Introduce the incorporation of a feedback wheel to indicate something has triggered the patient to enter the assessments and investigation phase of care
	
	Group Discussion
	• Ensure that dentists are included somewhere within the consumer health care journey, whether this be in the allied health practise, other services, or their own wheel. The current inclusions however, are non-exhaustive
	• The specialist practise wheel to medical specialist practise if this is the intention, as there can be specialised health practitioners like specialised stoma care nurses, specialised physiotherapists etc that may not explicitly fall within the medical description
	• As the wheel becomes more generic, the care team should be updated to be more condition-agnostic as a dietitian is more specific to diabetes whereas someone with osteoarthritis may find more benefit in a physiotherapist
	• This care team should include:
	  ○ GP
	  ○ Allied Health Professionals
	  ○ Family and Carers (including informal carers)
	  ○ Clinical Care Providers (e.g. NDIS workers, aged care providers)
	  ○ Other Care Providers
	  ○ Pharmacist
	• Pharmacists should be called out separately in the care team, as the way patients access their services is a different process
	• Social work would fall within other care providers
	• The middle wheel needs to be bigger to act as the 'hub', and the wheels surrounding the specialists on the outside are not needed as they feed into the main wheel and are not cyclical
	• Update the representation of data exchange to have more visual elements instead of just textually
	• Group agreed on the understanding that the diagram represents an individual who has a care team associated with them who are going through the chronic condition management care process, and are engaging with services which then feed back in to their ongoing chronic condition management
	
	Consumer Journey Wheel 2 – Singular layered wheel display
	• Seeking group feedback on this layout and whether two wheels are required
	• The structure of this diagram includes, from internal ring to external ring, the individual, care team, health care services, health care service phases, ongoing care coordination and

	management, and population health - see slide pack for more detail *Group discussion* • The ongoing care, coordination and management wheel was included in response to previous discussion to represent the ongoing care coordination and management for a patient with potentially multiple chronic conditions and to demonstrate the ongoing nature of the different phases within the journey • Potentially update the wording to of the ongoing care, coordination and management wheel to "ongoing care" or merge the ongoing care coordination and management wheel with others for clarity and better representation of the ongoing nature of chronic condition management • The current representation may be better used for a national representation however, for an individual journey the care team is the most integral the journey and should be the outer layer • Clarity around a patient accessing services in an ad hoc nature**,** and whether they are a part of the ongoing care team • Concerns were raised about the diagram potentially addressing too many things and that the display of data and information exchange is lost • Demonstrate which care team member is going to be with the patient consistently throughout the journey – this is often the GP • The population health wheel was intended to demonstrate the data and things happening within a patients health journey does get utilised within population health context however, this could be removed when the wheel is used in an individual context and instead be represented in the first diagram • Suggested to remove the 'healthcare services' ring and using the interactional flow from the first diagram • Include population health as a parallel process rather than integrating it into the central wheel
Workshop 2	*Chronic Condition Management Consumer Journey Timeline* • See slide pack for full detail • Updated version still has care team members and case scenario on the left side however, now includes separate headings for timeframe, stage, and activity, a section for care team members per stage, the data/information generated at each stage, and opportunities are grouped by topic for each stage • The journey represents 12 months and is broken into stages, some of which have been renamed

- An additional section for care team members, and patient empowerment and data and information within the opportunities section has been added
- Care team members have been added in including Maria's son, Enzo, a practise nurse, and a pharmacist
- Maria and her care team have been separated within the side panel
- The data and information section shows what may be created/accessed

Group Discussion

- When there are 3 of the same sets of data information, this should be included in the same order as the first three to highlight their differences in stages and to show the commonalities the same each time
- Use the active voice when discussing referrals for clarity (e.g. Dr Jones refer the patient)

General Feedback

- At previous meetings the feedback received for workflow and engagement, including risk factors, education, care team members and the support network and timing – see slide pack for full detail
- At previous meetings feedback was received for system-level opportunities, including reuse of existing data, patient contributions, clinical decision support, patient empowerment, and voice/dictation systems – see slide pack for full detail

CCM Timeline: Stage 1 – see slide pack for more detail and for the updated diagram

- Previous feedback on activities includes explicitly calling out the referral to the diabetes educator, the diabetes educator monitoring education and providing other diabetes management advice, and that the initiation of a care plan begins here
- The group previously asked for clarification around specialist involvement and the patients person support network within the care plan
- The updated stage 1 diagram shows Maria's journey as followed:
    - Maria is overwhelmed by the diagnosis but relieved to receive an explanation for recent fatigue
    - Maria's GP explains her condition, initiates a chronic condition management plan, and coordinates referrals including to a credentialed diabetes educator within the practice

    - The diabetes educator supports Maria in her understanding of the diagnosis and diabetes management
- The artefacts created during this stage include a chronic condition management care plan, a service request, an encounter record, and a patient summary
- The opportunities identified during this stage include:
- Patient empowerment: Maria accessing her chronic condition management plan to record her own goals and nominate members of her personal support network
- Data and systems – immediate: the creation of a chronic condition management plan FHIR questionnaire, a service request to relevant providers, updates to My Health Record,
- Data and systems – future: Maria's care team viewing and updating the CCMP (chronic condition management plan), CCMP linking to relevant guidelines and CDS tools to help 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, and updates to patient summary

Group Discussion

- Patient summary updates and shared health summaries in MHR are potentially two different things
- Currently a shared health summary is manually uploaded to MHR however, future models (like the Health Information Exchange**,** or HealthConnect Australia) might support real-time, aggregated summaries of patient data from multiple sources
- Concern raised about language like "updates to patient summary" might be misleading**,** since it implies there's a single, editable document like with MHR. Instead, "patient summary information is updated dynamically" or "data that supports a summary is updated" may be a more accurate description
- Hairy Question - Is this a living document model and can patients edit their health information (e.g. diabetes plans or vaccination history), or must updates come from clinicians?

CCM Timeline: Stage 2 – see slide pack for more detail and for the updated diagram

- Previous feedback includes clearly indicating a referral to a dietitian, represent that new clinicians may be temporary or ongoing, represent communication across the care team, highlight patient self-monitoring

- Previous feedback on technology and integration includes that systems generate prescriptions and update shared care plans, use of new technologies for patient to track activities/progress and potential upskill of Maria to use these, emphasise patient empowerment, and a question was raised around data responsibility
- The updated stage 2 diagram shows Maria's journey as follows:
    - Maria's dietitian and exercise physiologist receive referrals
    - The dietitian works with Maria to develop a nutrition plan and provides food intake guidance. They schedule a follow up appointment.
    - The exercise physiologist designs an individual physical activity plan and Maria begins daily walking
    - The practice nurse arranges a 3-month case conference for all members of Maria's care team
    - The GP prescribes medication
- Patient empowerment opportunities: Maria tracks her weight and activity in an app and the exercise physiologist has access to this and can provide support
- Data and systems – immediate opportunities: 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 opportunities: 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

Group discussion

- The GP is not only prescribing medication but is also reviewing the overall care and ensuring Maria's journey is on the right track
- The GP writing a prescription may be a complex step - diabetes management is complex with different medications and PBS restrictions and it's likely that decision support tools will be embedded within software systems to help with this
- Add vaccination within this step, as it has relevance to data systems and is a key part of prevention within diabetes management – this falls under broader overall prevention
- Maria's age puts her within the recommended age group for preventative bowel screening, of which she is at a greater risk of following her diabetes diagnosis
- Suggestion to remove that Maria has started walking daily, as a change in her diet is not explicitly called out with the dietitian's the nutrition recommendations, and could instead include the

high-level instructions from the care team (e.g. specific nutrition plan and exercise plan)
- It is ideal to have the patient involved however, this is not always a possibility

CCM Timeline: Stage 3 – see slide pack for more detail and for the updated diagram

- Previous feedback includes focusing on cardio/renal causes of fatigue, review biochemistry and integrate based on comorbidities, update language to "clinical decision support (CDS)", enable data links to pharmacy records, MyHR, PREMs/PROMs and assessment tools
- The updated stage 3 diagram includes:
    - Maria reports fatigue and confusion around medications
    - GP reviews Maria's lab results and liases with dietitian to review Maria's current dietary intake
    - The dietitian works with Maria to adjust current nutritional plan
    - Maria's pharmacist provides a home medicines review
- Current wording: Dr Jones reviews Maria's lab results, including FBC, HbA1c, lipids, LFT's, and urinary albumin, and liaises with Kate the dietitian to review Maria's current dietary intake
    - Question for CFG: High-light reuse of data more specifically through GP reviewing recent lab results available from other CIS, e.g. investigations ordered by other provider or recent visit to other clinic/hospital?
- Patient empowerment opportunities: use of PREMs/PROMs for monitoring of Maria's experience of fatigue, energy levels and wellbeing
- Data and systems – immediate opportunities: 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 opportunities: 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

Group Discussion

- Maria's fatigue be caused by reasons beyond cardio/renal and her GP will work with Maria to further understand what's happening with her health and potential alternate causes –

wording should be updated to reflect the broader range within the GP's role
- Look at the patient holistically, not just in relation to her diabetes
- As fatigue is a highly ambiguous symptom, suggested using a more straightforward or common symptom – routine review, vulval itching and discharge, increased urinary frequency, side effect of medication
- Suggested removing fatigue/energy from PREMs and instead just use PROMs, as PREMs don't measure fatigue
- The use of the term "confusion" may be misleading and proposed updating to "needs clarification"
- Update symptom being investigated to diarrhoea, as this is common side of Metformin which is often prescribed to type 2 diabetics
- If someone were having side effects like diarrhoea and were on a medication where this is a common side effect, the likely action is that this medication is reduced or stopped without undertaking additional investigations
- The dietitian can still be included within this step as Maria may have lost weight through the process, and her nutrition plan could be reviewed
- The CDE may also be relevant in this step if the dietitian is removed
- Update the stage to say that Maria sees her GP due to developing diarrhoea and the GP assesses and determines it's a side effect of the metformin

CCM Timeline: Stage 4 – see slide pack for more detail and for the updated diagram

- Previous feedback includes including a review by a health professional, consider using Aus CVD Risk Calculator, revisiting whether Maria's fatigue was followed up on
- The updated stage 3 diagram includes:
    - The GP follows up with Maria regarding her fatigue and Maria reports they are ongoing
    - Minor neuropathy detected in foot and eye check is clear
    - Podiatrist updates risk classification, optometrist uploads report
- <u>Question for CFG: Next step to action Maria's ongoing fatigue</u>
    - Order further investigations?
    - Refer to specialist, renal or cardio?
    - Other actions?
- Patient empowerment opportunities: Maria updates goals of care and accesses a current care summary

- Data and systems – immediate opportunities: Observations (foot risk, visual status) recorded, foot and eye screening data captured and shared promptly, updates to My Health Record
- Data and systems – future opportunities: Changes to CCMP notifies care team members, tailored by clinical preference or discipline, update to patient summary

Group discussion

- Update the follow-up to instead be that the diarrhoea has resolved but there is an increased HbA1c or higher glucose levels, something that indicates worsening blood glucose control, as a result of the cessation of the Metformin
- Non-pharmacological management is the first focus such as lifestyle and dietary management and continued engagement with the CDE however, there may be a consideration of adding in a second agent
- Stage 3 possibly involved referral to diabetes educator and Stage 4 could appropriately reflect a dietitian review
- Often stopping a medication is patient-led action, as the patient reports that the medication has given them negative side effects and they stop taking it

CCM Timeline: Stage 5 – see slide pack for more detail and for the updated diagram

- The stage 5 diagram includes:
    - Maria reflects on her journey and mild emotional distress is discussed
    - The GP reviews the full cycle and refers Maria to a psychologist, and renews CarePlan
- <u>Question for the CFG: Add in additional care team case conference as part of annual review?</u>

Group discussion

- Case conferences tend to be used when there is an unresolved issue or problem; if things are going reasonably well it is not assumed that this would be part of the journey as they are difficult to arrange
- Mild emotional distress can be managed with basic strategies, and a referral to a psychologist may be more relevant with moderate or severe emotional distress
- PROMs can serve as a trigger for intervention**,** particularly if they show declining mental well-being and should be actively used by the care team

	• Highlighted opportunity: Maria's PROMs being acknowledged and acted upon by the care team supports patient empowerment • Suggested to include Maria's son in the discussions, as this helps link that part of the care team in *Hairy Questions captured during discussion:* • 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.
Upcoming Meetings	Online Meeting 4 • Tuesday 3 June 11:00am – 1:00pm AEST Sparked Partners Symposium • Wednesday 28 May 9:00am – 4:45pm AEST Sparked CDG & TDG Face to Face Meeting • 29 & 30 July - Sydney

Decisions

ID	Description	Status	Comments
	Include medication side effect (in this case, diarrhoea) in the stage 3 example	Agreed	

Actions

ID	Description	Responsible	Due	Status

Attendees

1. Olivia Carter	2. Shelley Behen
3. Madison Black	4. Kylynn Loi
5. Nyree Taylor	6. Averil Tam
7. Jai Dacey	8. Fabrina Hossain
9. Heather Leslie	10. Jodie Sheraton
11. Oliver Frank	12. Sophie Tran
13. Steph Davis	14. Kath Feely
15. Sarah Pearson	16. Kim Drever

Apologies	
1. Adrian Gilliland	2. Antony David Sangster
3. Charlotte Hespe	4. Chris Boyd-Skinner
5. Eric Au	6. Harry Iles-Mann
7. Janney Wale	8. Kenneth Andrew Sikaris
9. Liz Keen	10. Melanie Smith
11. Nicola Mountford	12. Shannon Wallis
13. Troy Burgess	14. Josielli Comachio
15. William Smith	