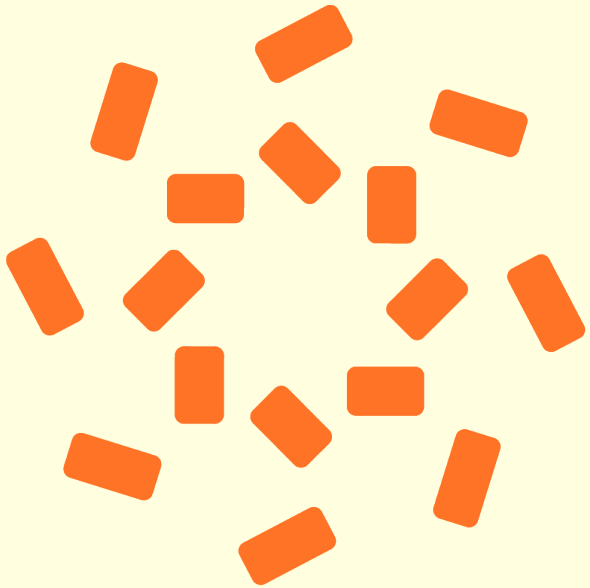


Sparked

HL7® FHIR®

Design Workshop

Wednesday 30 July 2025

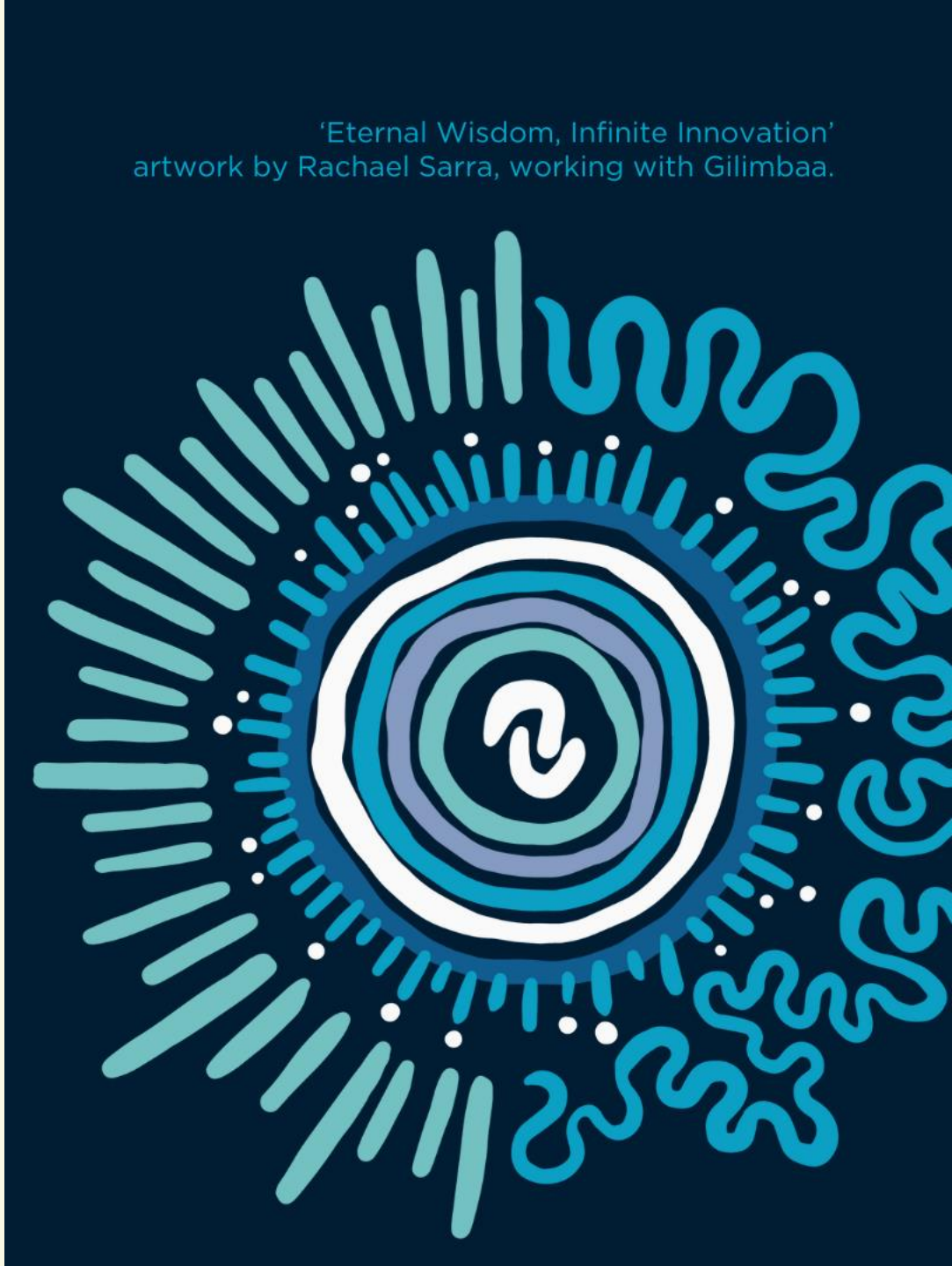
Sydney

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.



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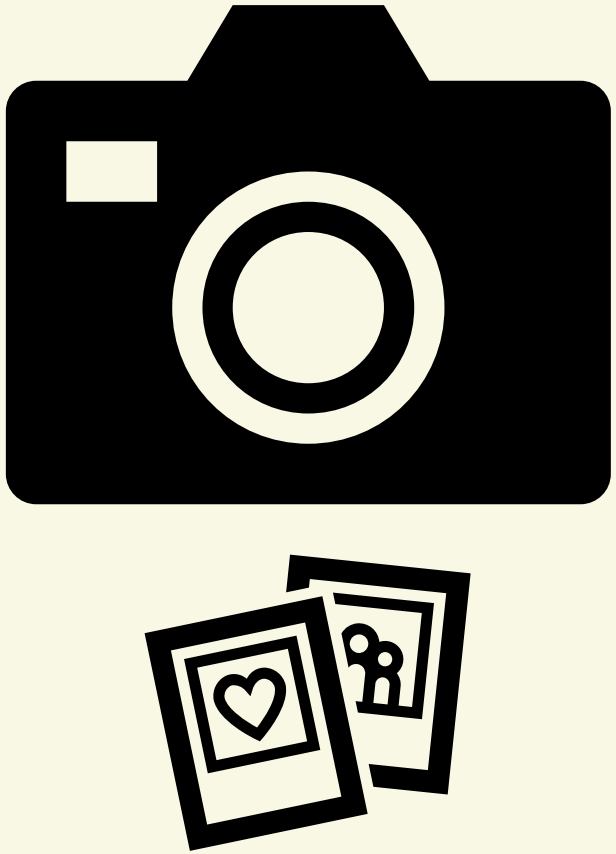
Photos/Video

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

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

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



Agenda

Agenda – Day 2		
Time	**Topic**	**Facilitator / Speaker**
8.30am	Registration	
9:00am	Welcome and introductions	Kate Ebrill
9.05am	Objectives and introduction to the day	Sparked team
Topic: Scene setting		
9.15am	GP Management Plan and health assessments	Imogen Colton (DHDA)
9.30am	Considerations and Opportunities for digitising CCM pathways	Jen Zacny (DHDA)
9.45am	Review & recap of Sparked Chronic Condition Management	Sparked team
10.10am	CCM CFG report back & overview of CCM Journey Timeline	Sparked team/ CCM CFG representative
10.30am	**Morning Tea**	
Topic: MVP requirements for CCM template (GPMP)		
11am	GPMP MVP introduction	Sparked team
11.15am	Workshop 1 Activity 1: Process/workflow for the GPMP MVP	Sparked team
11.45am	Report back	Sparked team
12.15pm	Workshop 1 Activity 2: Dev principles and design requirements of a GPMP MVP template	Sparked team
12.35pm	Report back	Sparked team
1.00pm	**Lunch**	

Agenda – Day 2		
Time	**Topic**	**Facilitator / Speaker**
1.00pm	**Lunch**	
Topic: CCM roadmap and future state		
1.45pm	CCM roadmap and future state introduction	Sparked team
2.00pm	Workshop 2 Activity 1: Detailed process/workflow for Chronic Condition Management	Sparked team
2.30pm	Report back	Sparked team
3.00pm	**Afternoon Tea**	
Topic: CCM roadmap and future state (part 2)		
3.30pm	Workshop 2 Activity 2: Prioritisation of features	Sparked team
4.00pm	Report back	Sparked team
4.30pm	Workshop 2 Activity 3: Build roadmap	Sparked team
4.45pm	Wrap up	Sparked team
5.00pm	Day 2 conclude	

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HL7 FHIR

Objectives

- Understand the CCM development to date
- Understand the changes to CCM and GP Management Plans
- Identify and prioritise the requirements for a GP Management Plan Template that is FHIR based, leveraging Sparked outputs.
- Explore a chronic condition management roadmap within the wider ecosystem

What are we actually doing today?

- Today's outcome- agree what the 'MVP' is for a FHIR enabled GP Management Plan but also importantly...
- Build the Chronic Condition Management Plan Roadmap for the future
- This day is about surfacing what *matters most* and building consensus around *what to do first*.
- The Chronic Condition Management Future we're informing:
  - Should reflect the *actual* workflow and language of frontline teams
  - Needs to make sense in real-world context, not ideal-world theory
  - Must be clinically safe, technically doable, and future-facing

Overview of workshops

Workshop 1

MVP

- Understanding clinical and technical requirements for a CCM plan template GPMP MVP and workflow mapping

Workshop 2

Roadmap and future state view

- Understanding the desired future state of chronic condition management plans, consumer empowerment and enabling digital infrastructure
- Understanding requirements of the interplay of CCM in the greater ecosystem of patient summary, referrals, encounter record, etc

Menti

Scene Setting

Department of Health, Disability and Ageing

Imogen Colton

Director, General Practice Section, MBS Policy and Reviews Branch

MBS Chronic Condition Management Framework and Health Assessments

Revised MBS framework is now in place

- Designed for patients with chronic conditions that would benefit from a structured approach to their care
- Revised framework for chronic condition management came into effect on 1 July 2025
- Streamline and modernise the arrangements
- GP Management Plan and Team Care Arrangement replaced by a single GP Chronic Condition Management Plan
- Patients with a plan can access MBS-supported allied health services

Patient Eligibility

- Patients are eligible if they have at least one medical condition that has been (or is likely to be) present for at least 6 months, or is terminal

- Different arrangements for residents of aged care facilities – coordination role for the facility

GP Chronic Condition Management Plan

- Plan is between the medical practitioner and the patient
- Documents the patient's condition(s), goals, actions to be taken, treatment and services likely to be needed
- If multidisciplinary care is required, the plan documents the services the patient will be referred to and the purpose of that service

GPCCMP – Required Contents

1. a written plan for the patient that describes:
    a. the patient's chronic condition and associated health care needs; and
    b. health and lifestyle goals developed by the patient and medical practitioner using a shared decision making approach; and
    c. actions to be taken by the patient; and
    d. treatment and services the patient is likely to need; and
    e. if the patient would benefit from multidisciplinary care to manage the chronic condition, the treatments or services to which the practitioner will refer the patient (including the purposes of those services); and
    f. arrangements to review the plan (including the proposed timeframe for review); and
2. if the patient is to be referred to a member or members of a multidisciplinary team for management of the patient's chronic condition:
    a. obtains the patient's consent to sharing relevant information, including relevant parts of the plan; and
    b. if the patient so consents—provides relevant parts of the plan to the members of the multidisciplinary team; and
3. records the patient's consent and agreement to the preparation of the plan; and
4. offers a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
5. adds a copy of the plan to the patient's medical records .

Referrals to Allied Health Services

The minimum requirements for a valid referral to an allied health provider:

- includes the name of the referring practitioner
- includes the address of the practice, or the practitioner's provider number at that practice, of the referring practitioner
- includes the date on which the referring practitioner made the referral
- the validity of the referral (if relevant)
- be in writing
- be signed by the referring practitioner (which may be by electronic signature)
- be dated
- explain the reasons for referring the patient, including any information about the patient's condition that the referring practitioner considered necessary to give the allied health professional.

MBS Health Assessments

Assessment Name	Patient Eligibility	Service Type	Availability
Aboriginal and Torres Strait Islander Peoples Health Assessment	Child less than 15 years People aged between 15 years and 54 years. People aged 55 years and older	Untimed	Once every nine months
Type 2 diabetes risk assessment	People aged 40-49 years with a high risk of developing type 2 diabetes	Time-tiered	Once every three years
Chronic disease risk assessment	People aged 45-49 years at risk of developing chronic disease	Time-tiered	Once only
Older persons health assessment	People aged 75 years and older	Time-tiered	Annually
Residential Aged Care Facility (RACF) - comprehensive medical assessment	Permanent RACF residents	Time-tiered	On admission to a facility, then annually
Intellectual disability – comprehensive medical assessment	People living with an intellectual disability	Time-tiered	Annually
Refugee and other humanitarian entrant health assessment	Humanitarian entrants holding a relevant visa type	Time-tiered	Once only
Veterans' health assessment	Former serving members of the Australian Defence Force	Time-tiered	Once only
Heart health assessment	People aged 30 years and older	20+ minutes	Annually
Menopause and perimenopause	Patients experiencing premature ovarian insufficiency, early menopause, perimenopause or menopause symptoms	20+ minutes	Annually

Department of Health, Disability and Ageing

Jen Zacny

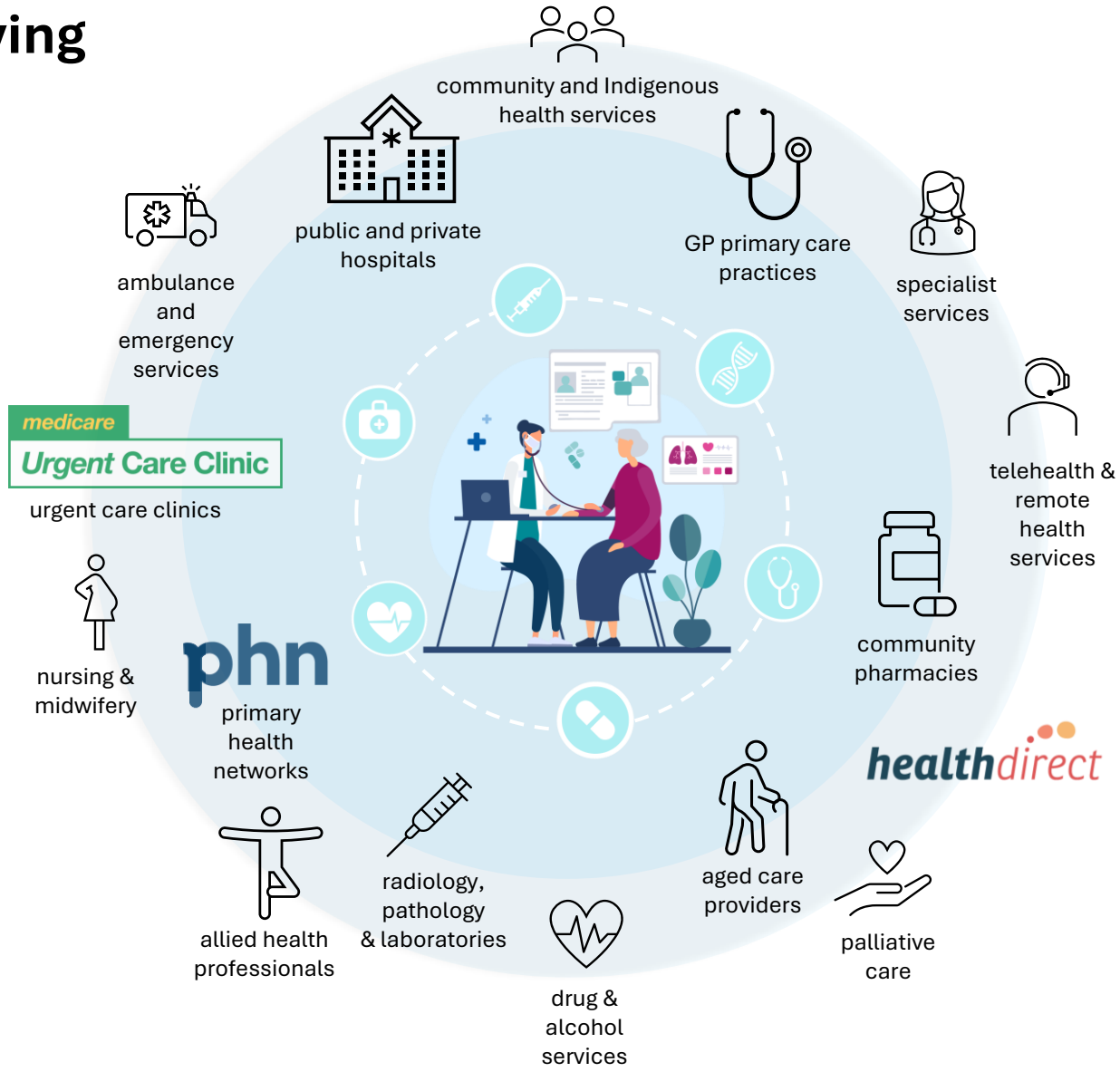
Director, Digital Health Strategy, Digital Health Branch

Our digital health initiatives aim to connect all parts of the health system, improving healthcare access, experience and outcomes for all Australians

We are driving towards a modern health system that provides a more connected care experience for all Australians...

...where health information is organised around the patient so that it can be easily accessed by all members of their healthcare team, no matter where they present...

...and consumers can easily navigate between services, providers and care settings, to access the right care at the right time.



Clinical handovers are safer and more seamless when information follows the patient

Virtual and/or After-Hours Care

Oliver accesses a virtual GP consultation - an **encounter record** is created and shared to his usual GP and My Health Record.

Diagnosis and Care Planning

! Oliver's usual GP is notified of his encounter with virtual care.

After a **Health Assessment** is conducted, Oliver and his GP set up a **Chronic Condition Management Plan,** recording his healthcare needs, health and lifestyle goal and agreed actions, treatment and services.

Treatment and Management

Oliver's care team review his **care plan** to tailor treatment plans and access his **patient summary** for relevant health history, such as recent procedures, allergies and medications.

Oliver's care team contribute **encounter record** updates on his treatment progress and any follow up actions.

Patient Summary

Problems ~ Allergies ~ Medications ~ Procedures ~ Immunisations ~ Results

Sparked CCM recap

Kate Ebrill and Kylynn Loi

AUCDI Release 2 – Chronic Condition Management

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

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

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

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

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

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

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

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

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

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

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

Education summary
- Overview
- Highest level completed
- Last updated

Financial summary
- Overview
- Financial stability status
- Last updated

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

Housing summary
- Overview
- Housing stability status
- Last updated

Living arrangement summary
- Overview
- Last updated

Occupation summary
- Overview
- Last updated

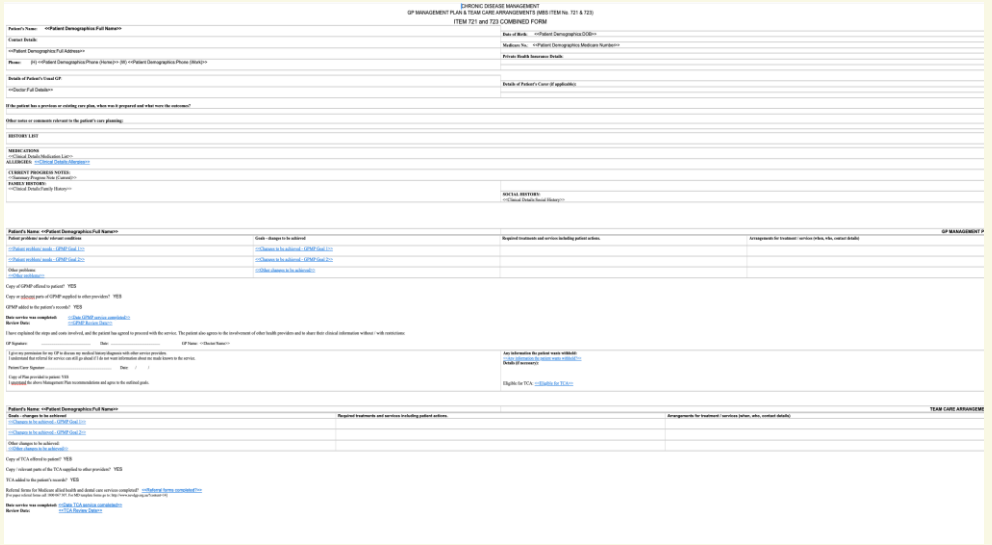
Physical activity summary
- Overview
- Last updated

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

Adelaide CDG February 2025

- CDG
  - Updates from DOHAC and ADHA
  - Showcase from SA Health
    - Interoperability update
    - Ambulance Patient Care Record project (amPHI) in South Australia implementing FHIR, AU Core and SNOMED CT-AU
  - Workshops
    - Chronic Condition Management plan template
    - Encounter summary/reason for encounter
    - Patient story

Team Care Arrangement/Chronic Condition Management Plan



TCA/GP Management Plan Template?

Sparked - AUCDI, AU Core

FHIR

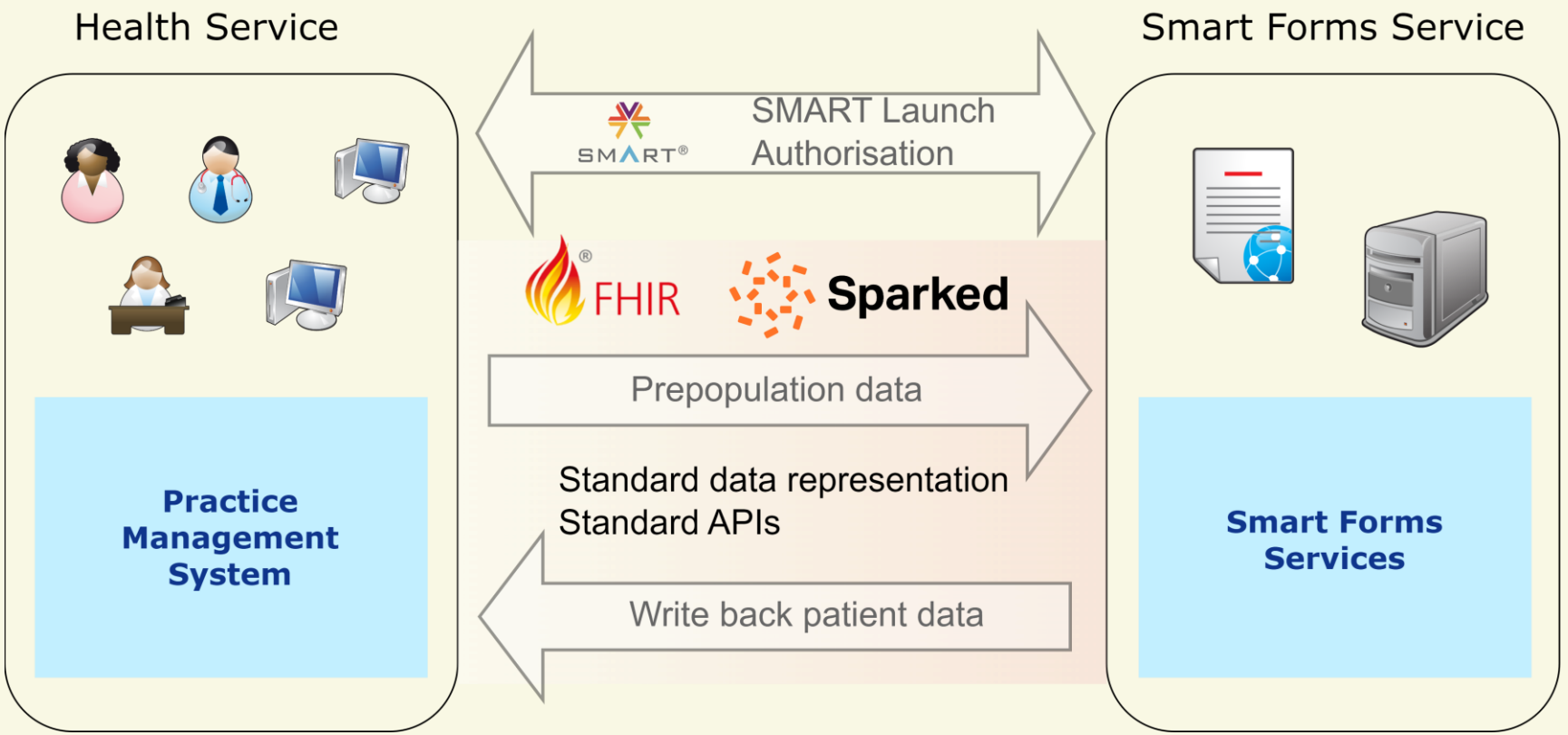
Smart forms

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

Smart Forms Principles

- Forms based solution for health assessments
- Capable of integrating into existing clinical systems
- Data exchange and reuse
- Data quality improvement
- Improve efficiency for delivering clinical care

Interface


Health Service
Smart Forms Service
SMART
SMART Launch
Authorisation
FHIR
Sparked
Prepopulation data
Standard data representation
Standard APIs
Write back patient data
Practice Management System
Smart Forms Services

Smart Health Checks

Aboriginal and Torres Islander Health Check Assessment

- Smart Forms software
- FHIR Implementation Guide

Thanks to the sponsor

First Nations Health Division, Department of Health and Aged Care

National SMART App Initiatives

- First Nations Peoples Health Check
  - Smart Forms App
- Comprehensive Health Assessment Program (CHAP) (ADHA)
  - Smart Forms App
- Aus CVD Risk-i Calculator
  - SMART App
- + more

Exchange requirements

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

GP MANAGEMENT PLAN (MBS ITEM No. 721)

Patient's Name: <<Patient Demographics:Full Name>>	**Date of Birth:** <<Patient Demographics:DOB>>
Contact Details: <<Patient Demographics:Full Address>>	**Medicare or Private Health Insurance Details:** <<Patient Demographics:Medicare Number>> <<Patient Demographics:Health Insurance>>
Details of Patient's Usual GP: <<Doctor:Name>> <<Doctor:Full Address>>	**Details of Patient's Carer (if applicable):**

Date of last Care Plan/GP Management Plan (if done): <<Date of last Care Plan/GPMP>>

Other notes or comments relevant to the patient's management plan:

PAST MEDICAL HISTORY

<<Clinical Details:History List>>

FAMILY HISTORY

<<Clinical Details:Family History>>

MEDICATIONS

<<Clinical Details:Medication List>>

ALLERGIES

Patient's Name: <<Patient Demographics:Full Name>>

GP MANAGEMENT PLAN

Patient problems / needs / relevant conditions	Goals - changes to be achieved	Required treatments and services including patient actions	Arrangements for treatments/services (when, who, and contact details)
A	1 2 3	T (1) T T	

Problem/diagnosis/ needs/health issue

Goals

Interventions (treatments and services), incl patient actions

Arrangements for interventions

Copy of GP Management Plan offered to patient? <<Copy of GPMP offered to patient?>>

Copy / relevant parts of the GP Management Plan supplied to other providers? <<Copy of GPMP supplied to other providers?>>

GP Management Plan added to the patient's records? <<GPMP added to patient's records?>>

Date service was completed: <<Date service completed>>	**Proposed Review Date:** <<Proposed review date (recommended 6 months)>>

I have explained the steps and any costs involved, and the patient has agreed to proceed with the plan. <<Steps and costs explained, patient agreed>>

GP's Signature: _____ Date:_____

Patient details
Usual GP details

Care plan details

Patient summary information

The management plan

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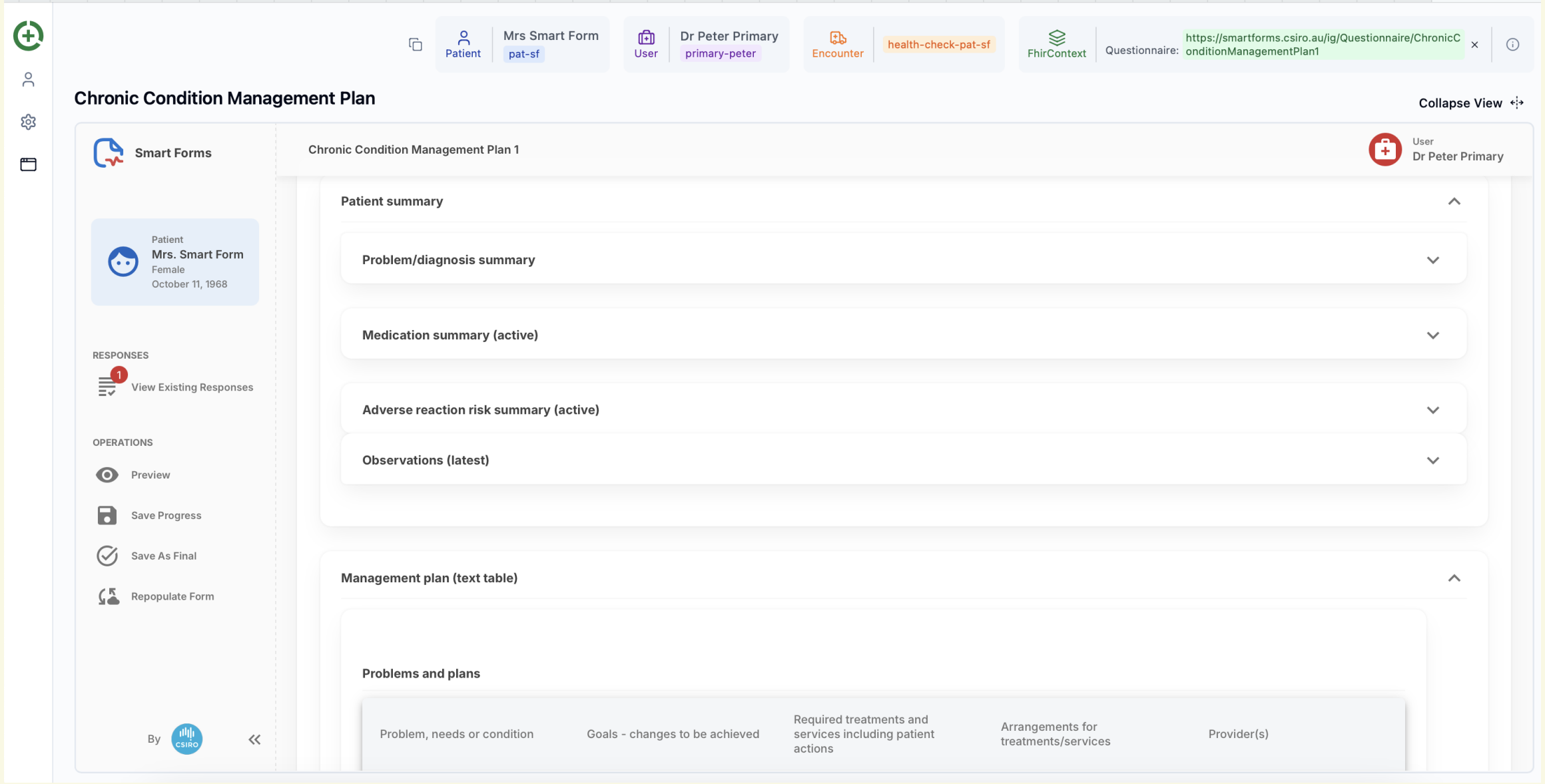
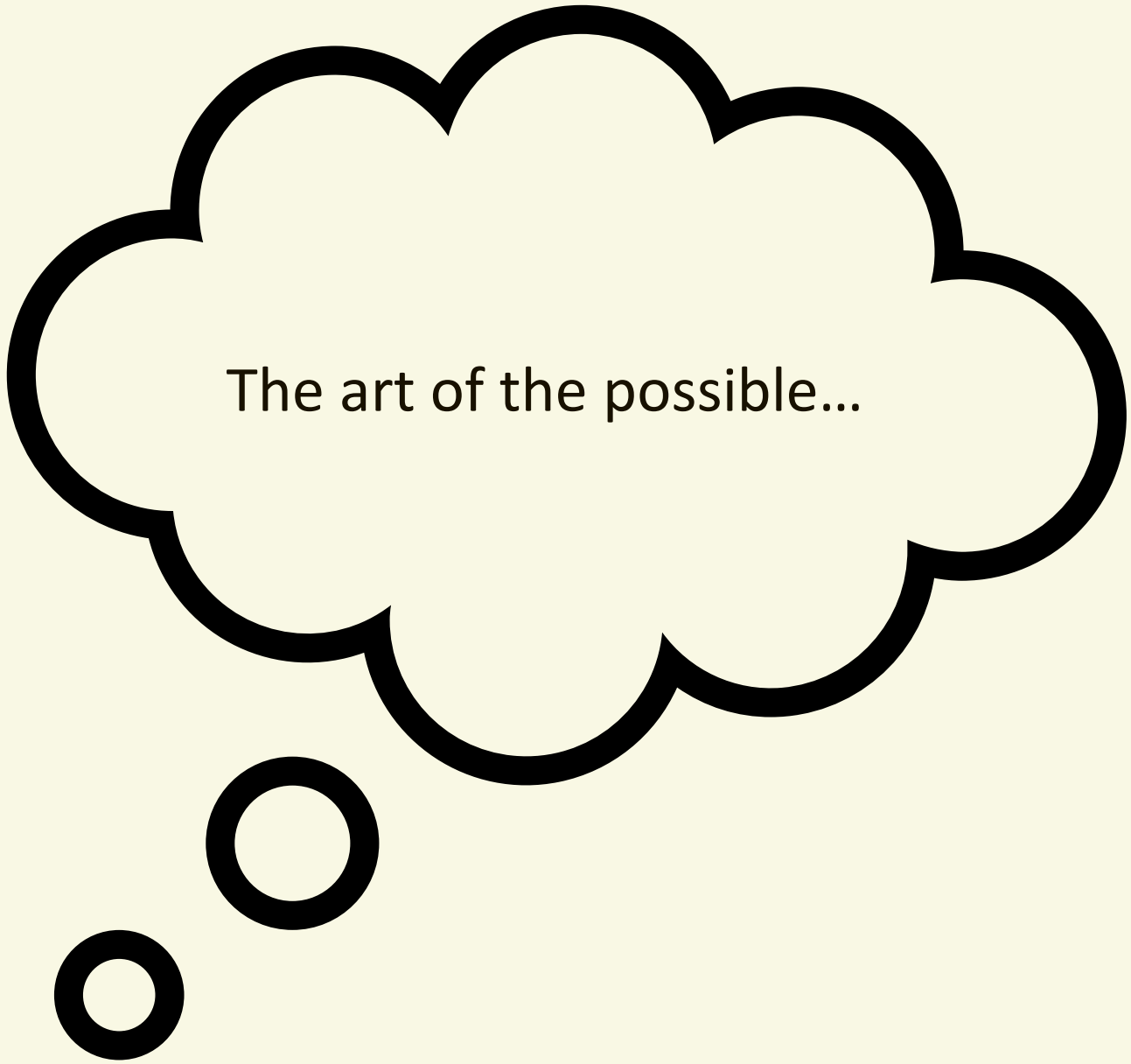
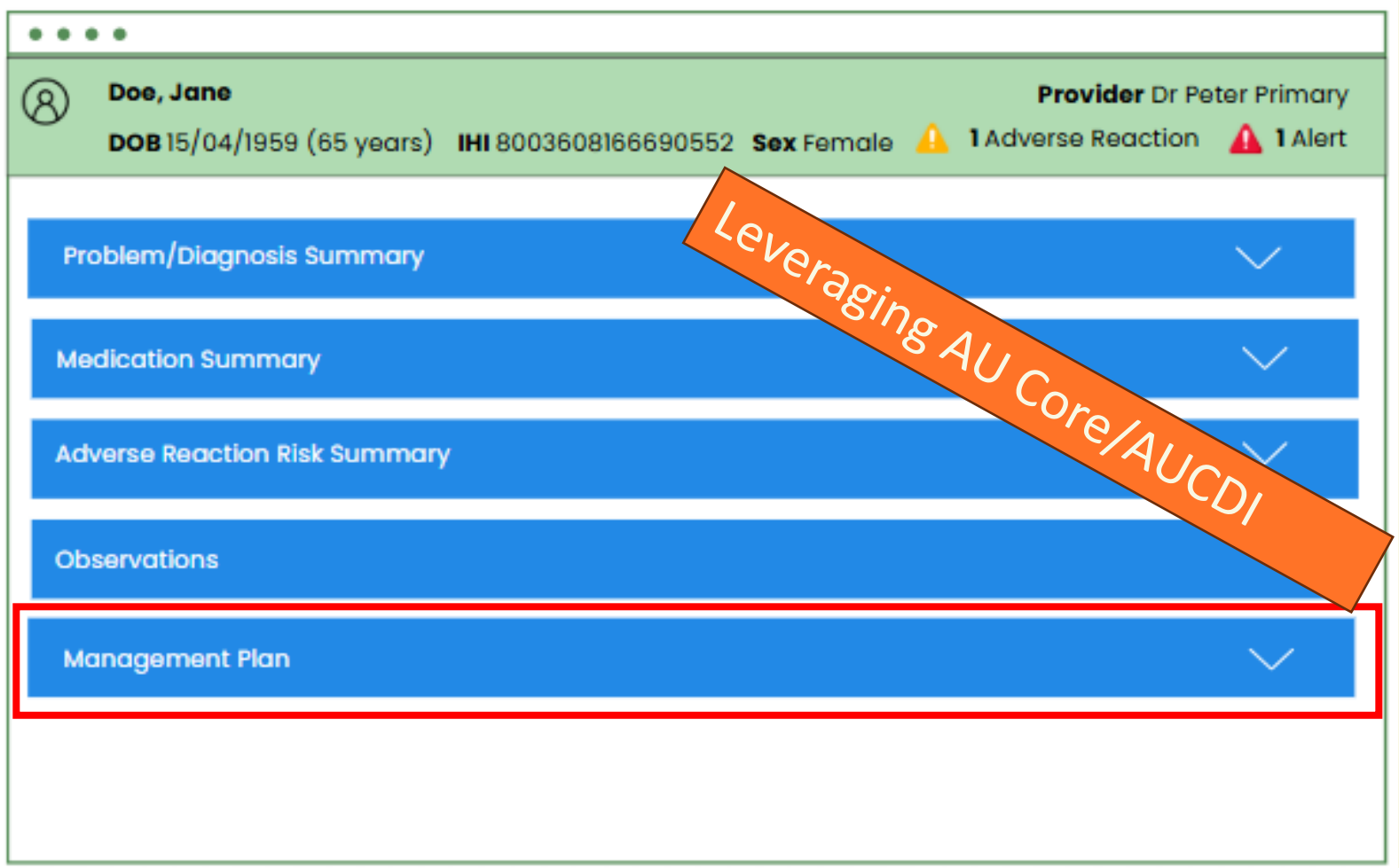
Murrumbidgee PHN Generic GPMP/TCA plan

GP MANAGEMENT PLAN - MBS ITEM No. 721 (DIABETES)			
Patient problems / needs / relevant conditions	**Goals - changes to be achieved**	**Required treatments and services including patient actions**	**Arrangements for treatments/services (when, who, contact details)**
1. General			
Patient's understanding of diabetes	Patient to have a clear understanding of diabetes and patient's role in managing the condition	Patient education	GP / nurse Diabetes educator
2. Lifestyle			
Nutrition	Maintain healthy diet	Patient education OR As per Lifescripts action plan	GP to monitor Dietician
Weight	Your target: BMI < __ Ideal: BMI ≤ 25 kg/m^2	Monitor Review 6 monthly OR As per Lifescripts action plan	Patient to monitor GP/nurse to review
Physical activity	Your target: Ideal: Exercise at least 30 minutes walking or equivalent 5 or more days per week	Patient exercise routine OR As per Lifescripts action plan	Patient to implement
Smoking	Complete cessation	Smoking cessation strategy: Consider: - Quit - Medication OR As per Lifescripts action plan	Patient to manage GP to monitor
Alcohol intake	Your target: < __ standard drinks per day Ideal: ≤ 2 standard drinks per day (men) ≤ 1 standard drinks per day (women)	Reduce alcohol intake Patient education OR As per Lifescripts action plan	Patient to manage GP to monitor
3. Biomedical			
Cholesterol/Lipids	Your targets: LDL < __ Cholesterol < __ HDL > __ Triglycerides < __ Ideal: LDL < 2.5 mmol/L Cholesterol < 4.0 mmols/L HDL ≥ 1.0 mmol/L Triglycerides < 2.0 mmol/L	Annual check	GP
Blood pressure	Your target: < __ Ideal: < 130/80 mm Hg	Check every 6 months	GP/nurse
HbA1c	Your target: < __ Ideal: ≤ 7%	Check every 6 months	GP/nurse
Blood glucose level	Your target: < __ Ideal: < 7 mmols/L (4-6 fasting)	Daily monitoring Check every 6 months	Patient GP/nurse
4. Medication			
Medication review	Correct use of medications, minimise side effects	Patient education Review medications	GP to review and provide education
5. Complications of diabetes			
Eye complications	Early detection of any problems	Eye check every 2 years Referral by GP	GP Eye specialist
Foot complications	Prevent foot complications	Patient education on foot care Patient to check feet regularly Check feet every 6 months	GP / podiatrist / nurse Patient GP
Kidney damage	Avoid renal complications Your targets: < __ µg/min timed overnight collection < __ mg mg/L spot collection < __ mg/mmol women < __ mg/mmol men albumin creatinine ratio Ideal: < 20 µg/min timed overnight collection < 20 mg mg/L spot collection < 3.5 mg/mmol women < 2.5 mg/mmol men albumin creatinine ratio	Test for microalbuminuria annually	GP
Sexual dysfunction	Maintain sexual function	To be discussed with patient where applicable	GP


Patient
Mrs Smart Form
pat-sf
User
Dr Peter Primary
primary-peter
Encounter
health-check-pat-sf
FhirContext
Questionnaire:
https://smartforms.csiro.au/ig/Questionnaire/ChronicConditionManagementPlan1
Chronic Condition Management Plan
Collapse View
Smart Forms
Chronic Condition Management Plan 1
User
Dr Peter Primary
Patient summary
Patient
Mrs. Smart Form
Female
October 11, 1968
Problem/diagnosis summary
Medication summary (active)
Adverse reaction risk summary (active)
Observations (latest)
RESPONSES
View Existing Responses
OPERATIONS
Preview
Save Progress
Save As Final
Repopulate Form
By
CSIRO
Management plan (text table)
Problems and plans
Problem, needs or condition
Goals - changes to be achieved
Required treatments and services including patient actions
Arrangements for treatments/services
Provider(s)


The art of the possible…

Chronic Condition Management Plans



Adelaide Outputs- usability principles

Access

- Patient access and contribution (e.g. update status of goals)
- Data sharing – Consent, privacy principles
- Carer access and validation
- Dynamic Real-time information transfer/contribution (not a PDF)
- Multi-practitioners able to access and update
- Ensure proper communication between providers and patient
- Integration with practice software

Support team care contributions

- Team members – when joined, left, context
- Multiple contributers from different organisations
- Care team function - roles – owner, contributor, informational
- Support patient self-management
- Irrelevant of eligibility of programs
- Understand why particular pathways were not continued

Traceability of information

- Visibility of source

Visibility/Presentation of information

- Problems/ diagnoses, summary of chronic conditions
- Communication tips for effective outcomes
- Flexibility of retrieving more current information
- Timelines/dates for when conditions occurred/resolved, progress easy to track
- Different views – summary, user based, condition based, customizable

Inclusion of Information (content)

- Free text AND coded information should be allowed
- Prepopulation of relevant ifno
- Goals should be manageable and agreeable
- Health issues – what the patient sees as the current issue
- RAG status – how far along are you
- Updated contact details of all providers
- Wearables data

Use of CDS tools

- Trigger alerts
- Prompt clinicians to ask appropriate questions
- Linking information/ standardized actions against best practice guidelines

Link to Referrals

- Links back to referrals

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Adelaide Outputs- Workflow challenges

Need to form consensus

- Goals
- Updates to care plan

Communication

- Accessibility of care plan
- Ensuring information finds appropriate destination (directory)
- Need for acknowledgement
- Authentication
- Shared view
- Patient admin systems data exchange and sync
- Integration of test and imaging requests, referral workflow
- Provenance of information

Care team

- Lack of provider/Health registry
- Limited widespread formal CCM
- Difficulty of identification of eligible patients for care plan
- Multiple care providers involved
- Need to include patients and carers
- Need for reviews and status updates
- original date goal due, number of revisions and current dates
- Supporting synchronous and asynchronous outcomes and interactions
- Role and accountability
- Funding models

Curation of Patient information

- Maintenance and curation of information/ too much information
- Need a depth of information but then that needs to be curated

Patient

- Readiness of patient to engage in self-management
- Not all have a regular GP
- Currently patient-initiated care not included
- Acceptance/ consent
- Regard patient engagement with activities

Care management

- Limited widespread formal CCM

Summary Additional information that should be recorded or additional features

- Priority of conditions (when multiple)
- Funding accessibility
  - Pension/NDIS/Medicare/MBS billing
- Outcomes
  - Measurable outcomes
- Patients
  - health values and prioritisations
  - Preferences, barrier to care
  - SDOH factors
  - Health concerns and problems
  - Self management/empowerment principles/considerations
- Goals
  - SMART formatted
  - Measurable
  - Barriers to achieve
  - Urgency
  - Ownership
  - Timeframes
  - Personal goals/clinical goals
  - Agreement of goals by patient and GP
- Activities
  - Ownership
  - Information re historical interventions/goals
  - Self management/education
- Care team details
- Follow up flags
- Referral recommendations
  - Noting patient affordability for team and services when may prevent evidence-based goals being included due to non-accessibility
- Integration with
  - Provider registry
  - eRequesting
  - eReferrals
- Updates to the care plan from all involved providers
- Guidelines – easily retrieved or embedded
- Provenance of information
- Control of accessible data - – make the clinically relevant information available to the right team member and the team when they are engaged with care
- Reports/monitoring metrics (patients pov as well)

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CCM Focus Group update

Tor Bendle

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

- Provide targeted clinical support to enable the development of **Chronic Condition Management priorities**
  - 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**

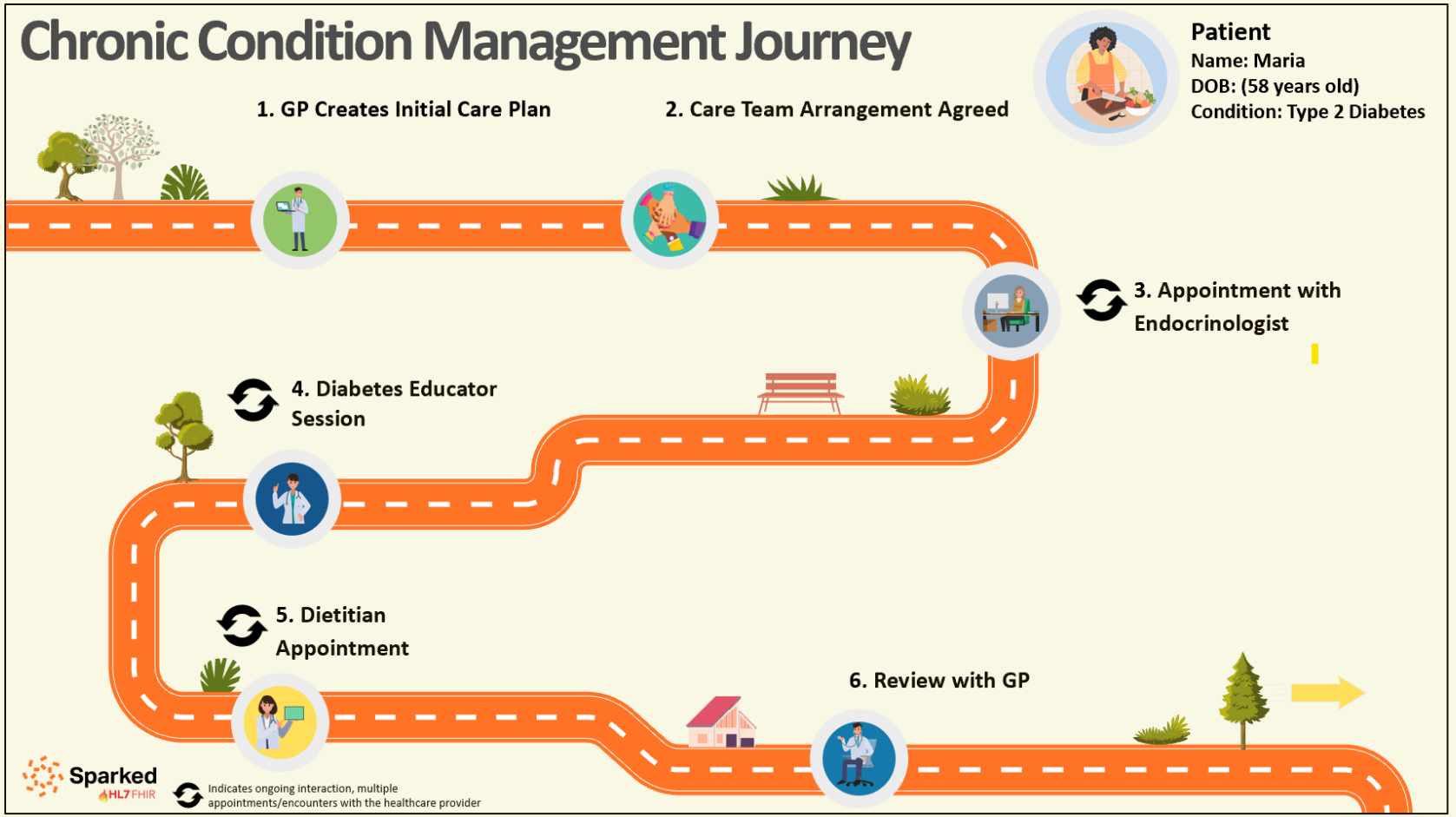
What have e CCM CFG been doing?

- 4 meetings from April to June 2025

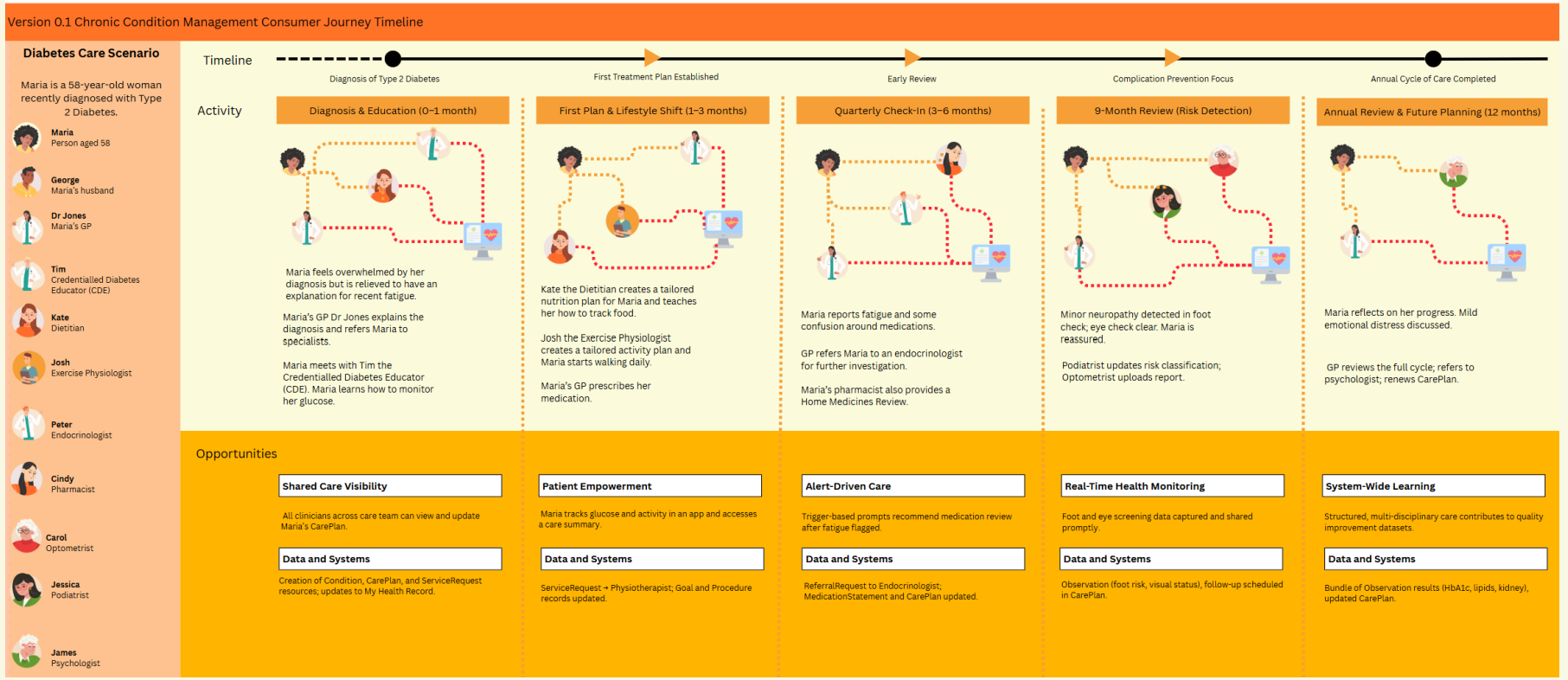
- Started out talking about creating an example of a Chronic Condition Management Journey should look like
- Rapidly evolved in complexity…..

Where we started…

We proposed a simple journey diagram similar to what was produced for Patient Summary..



Levelling up



- Restructured the format.
- Included additional sections, i.e.:
  - Separated out the stages,
  - Added a timeline
  - Activity for each stage
  - Added additional detail into the story section of the stage
  - Section to call out the different opportunities for each of the stages

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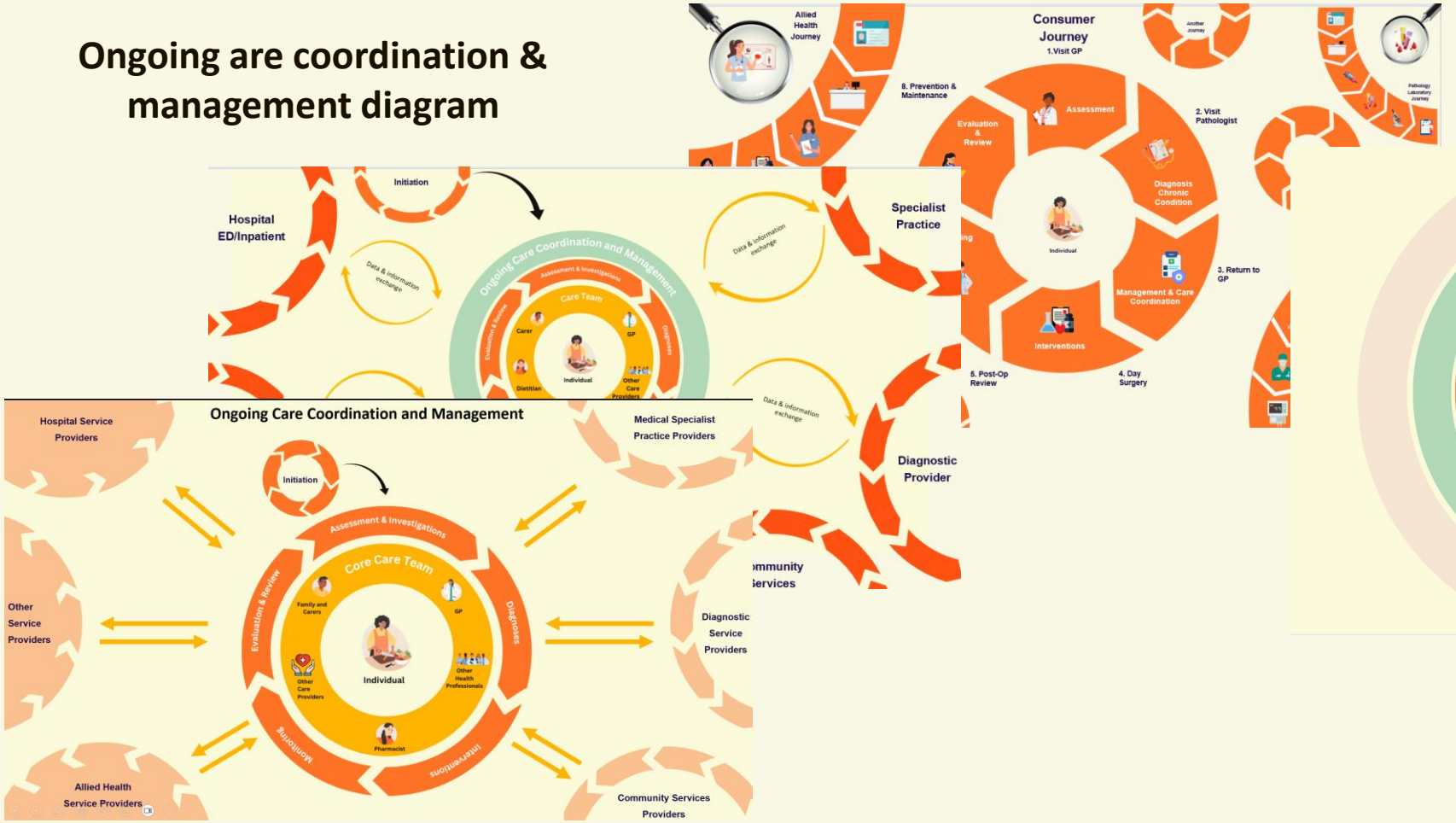
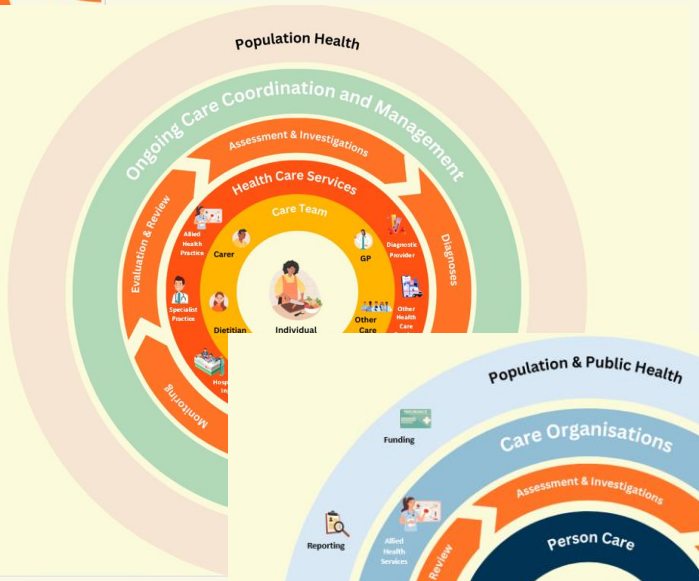
Levelling up continued..

Ongoing are coordination & management diagram



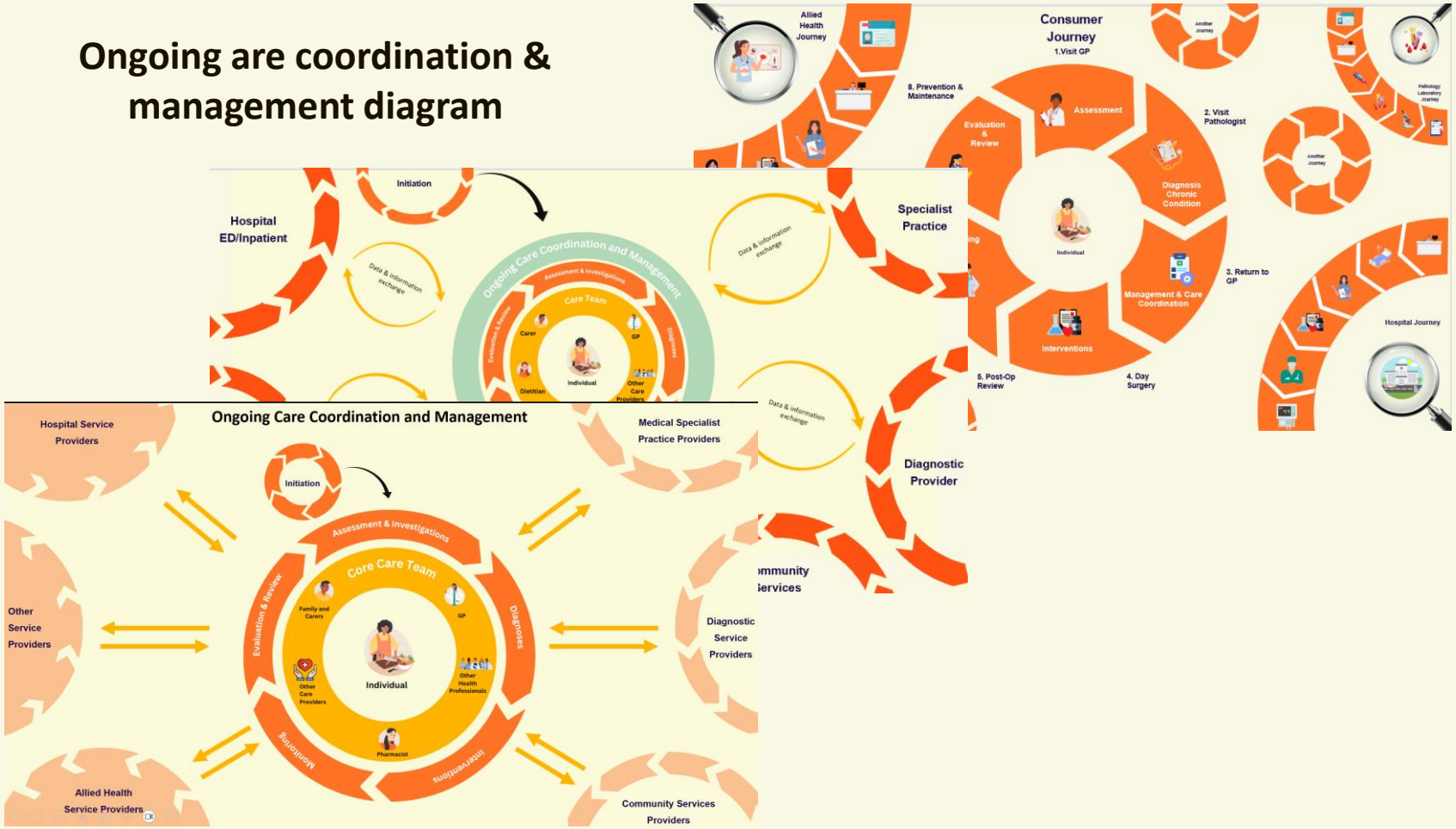
Primary to population' CCM wheel



Sparked HL7 FHIR

Levelling up continued..

Ongoing are coordination & management diagram



Purpose:

To simply demonstrate the relationship and interactions between the individual, the core care team, the phases or stages of care coordination and the interactions with the different healthcare service providers.

Levelling up continued..

Purpose:
To show 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.

Primary to population' CCM wheel

Sparked HL7 FHIR

Focussing back on the CCM Journey

Version 0.4 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
- **Eleanor** — General Practitioner
- **Amanda** — Practice Nurse
- **Tim** — Credentialled Diabetes Educator (CDE)
- **Kate** — Dietitian
- **Josh** — Exercise Physiologist
- **Cindy** — Pharmacist
- **Carol** — Optometrist
- **Jessica** — Podiatrist
- **James** — Psychologist

Auxiliary/Extended Care Team

The care team members below represent a non-exhaustive list of health professionals or Caterina's support network who may be involved in supporting Caterina's health on an intermittent, consultative or outreach basis. This list of additional care team members is intended to highlight the complex and evolving nature of a care team involved in supporting a consumer living with one or multiple chronic conditions.

- **Enzo** — Caterina's son
- **Bryce** — Endocrinologist
- **Sallie** — Cardiologist
- **Aida** — Wound care nurse
- **Miranda** — Ophthalmologist

	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)

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

Caterina's General Practitioner, Eleanor, provides an explanation of her condition, initiates a Chronic Condition Management Plan (CCMP), and coordinates referrals to multiple healthcare providers, including a Dietitian, an Exercise Physiologist, an Optometrist and a Podiatrist.
Eleanor (GP) also refers Caterina to Tim, the Credentialled Diabetes Educator based within the practice.

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

Caterina also discusses her recent diagnosis with her regular pharmacist, Cindy, who offers support and education to help Caterina understand the changes to her medication regimen.

Kate the Dietitian works with Caterina to develop a personalised nutrition plan and provides guidance on tracking her food intake. Kate (Diet) 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.

Eleanor (GP) reviews Caterina's care plan and notes Caterina's blood glucose levels are outside target range. Eleanor (GP) adjusts Caterina's current medications, requests updated blood tests and arranges a follow-up visit to monitor progress.

Caterina presents to Eleanor (GP) with some questions regarding her medications. Caterina reports that she has been experiencing diarrhoea when taking metformin and has stopped using it.

Eleanor (GP) assesses Caterina, checks her recent lab results and reviews her current list of medications. Eleanor (GP) agrees with ceasing Caterina's metformin.
Caterina also meets with Tim (CDE) who provides additional support and education to Caterina.

Cindy (Pharm) 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.

Eleanor (GP) follows up with Caterina regarding her diabetes control, confirms the diarrhoea has ceased, and identifies Caterina's recent HbA1c and blood glucose levels remain outside target range. Eleanor (GP) recommends Caterina consults with her regular dietitian to review her current dietary intake.

Eleanor (GP) also reviews Caterina's vaccination status and advises updates for pneumococcal, and COVID-19 vaccines.

Kate (Diet) works with Caterina to review her current dietary intake, adjust her nutritional plan and provides guidance to support improved glycaemic control.

Caterina's optometrist, Carol, undertakes a routine comprehensive eye exam; Carol (Opt) reports no signs of diabetic retinopathy or other complications.

Caterina also attends a routine foot check-up with Jessica the Podiatrist. Minor neuropathy detected during foot exam. Jessica (Pod) documents her findings and consults with Eleanor (GP) to ensure ongoing monitoring & follow-up.

At Caterina's next appointment, Eleanor (GP) observes a shift in her emotional state and reviews Caterina's recent PROMs results. George, Caterina's husband, 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 and continuing to work full-time.

Amanda (RN) and Eleanor (GP) work closely together to arrange regular check-ins that include Caterina's husband, to monitor Caterina's emotional wellbeing and ensure her support network remains actively involved in her care.

Eleanor (GP) refers Caterina to James, the Psychologist. Together, James (Psych) 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	Eleanor (General Practitioner), Tim (Credentialled Diabetes Educator (CDE)), Cindy (Pharmacist)	Eleanor (General Practitioner), Kate (Dietitian), Josh (Exercise Physiologist), Amanda (Practice Nurse)	Eleanor (General Practitioner), Tim (Credentialled Diabetes Educator (CDE)), Cindy (Pharmacist)	Eleanor (General Practitioner), Kate (Dietitian), Carol (Optometrist), Jessica (Podiatrist)	Eleanor (General Practitioner), Amanda (Practice Nurse), George (Caterina's husband), 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 is readily accessible & exchangeable source of data for Australian patient summary information
- Australian patient summary information is readily accessible to care team members as required

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
- Pharmacy dispense records available & synchronised with medication information where applicable
- Ability for Caterina to record her medication usage within the CCMP for visibility to the care team
- 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 is readily accessible & exchangeable source of data for Australian patient summary information
- Australian patient summary information is readily accessible to care team members as required

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.
- Pharmacy dispense records available & synchronised with medication information where applicable
- Ability for Caterina to record her medication usage within the CCMP for visibility to the care team
- Changes to CCMP notifies care team members, tailored by clinical preference or discipline.
- Encounter record information is readily accessible & exchangeable source of data for Australian patient summary information
- Australian patient summary information is readily accessible to care team members as required

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 is readily accessible & exchangeable source of data for Australian patient summary information
- Australian patient summary information is readily accessible to care team members as required

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

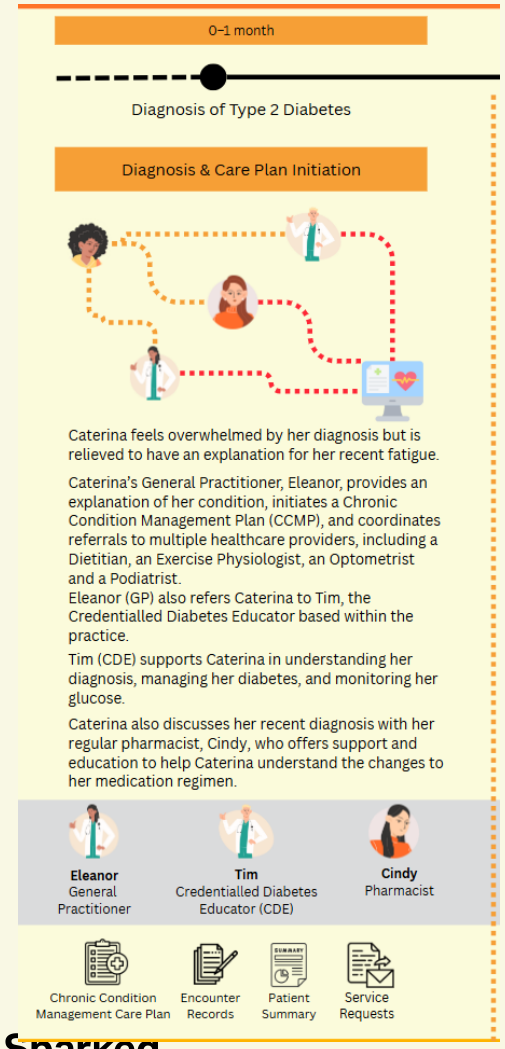
- All members of Caterina's care team can view and update Caterina's CCMP
- System trends PROMs data over time and clinical decision support recommends best practice interventions or follow-up to relevant care team member(s) as required
- Changes to CCMP notifies care team members, tailored by clinical preference or discipline
- Relevant information from existing CCMP is accessible & exchangeable source of information when creating new/additional care plans, e.g. mental health treatment plans
- Encounter record information is readily accessible & exchangeable source of data for Australian patient summary information
- Australian patient summary information is readily accessible to care team members as required

#006
Charizard
Fire · Flying

Focussing back on the CCM Journey - Overview

- Summary:
  - Caterina, is a 55-year-old woman recently diagnosed with Type 2 diabetes.
  - Looking at the first 12 months post her diagnosis
  - Focussed on Caterina's diabetes diagnosis experience
    - Noting - in the real-world, Caterina would likely have multiple diagnoses being managed at the same time
  - Caterina's journey highlights a person-centred, multidisciplinary approach to chronic condition management.
  - Identifies *some* of the interactions that our consumer has with the healthcare system and the different members of her Care team, and how a Chronic Condition Management Plan may be used to help support that ongoing care coordination across settings.

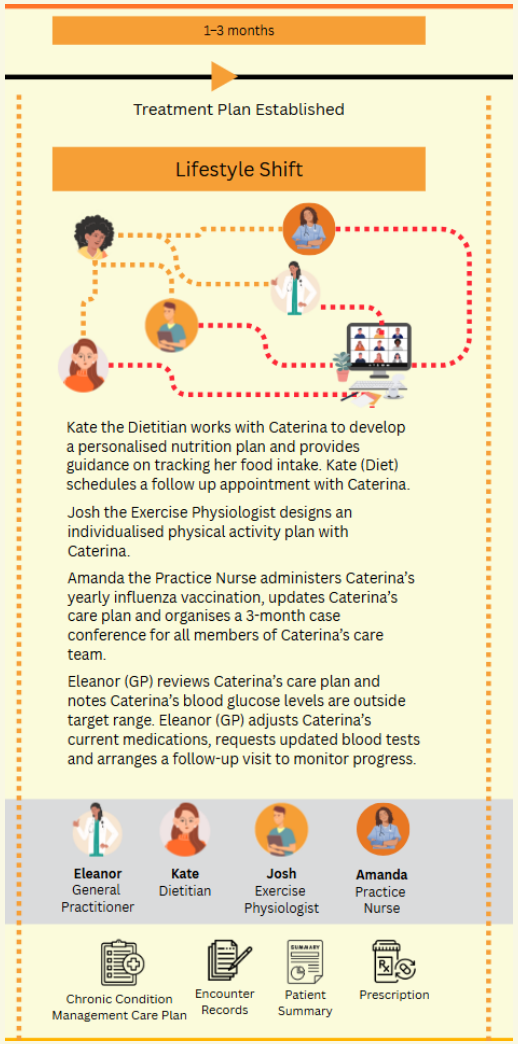
Caterina's Story – 1



Caterina feels **overwhelmed by her diagnosis** but is **relieved to have an explanation** for her recent fatigue.
Caterina's **General Practitioner, Eleanor**, provides an explanation of her condition, **initiates a Chronic Condition Management Plan (CCMP)**, and **coordinates referrals to multiple healthcare providers**, including a **Dietitian**, an **Exercise Physiologist**, an **Optometrist** and a **Podiatrist**.
Eleanor (GP) also refers Caterina to Tim, the **Credentialled Diabetes Educator** based within the practice.
Tim (CDE) supports Caterina in understanding her diagnosis, managing her diabetes, and monitoring her glucose.
Caterina also discusses her recent diagnosis with her regular **pharmacist**, Cindy, who offers support and education to help Caterina understand the changes to her medication regimen.

Sparked HL7 FHIR

Caterina's Story – 2



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

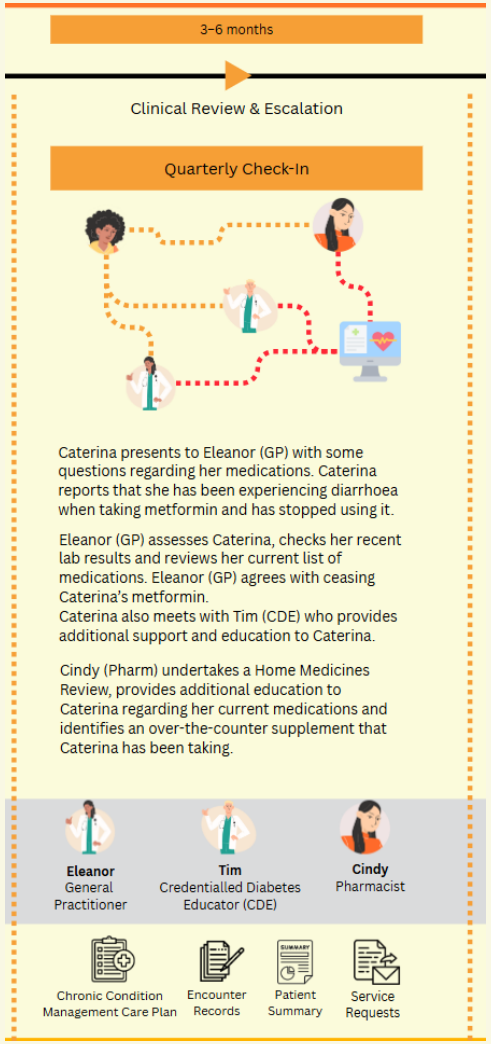
Josh the **Exercise Physiologist** designs an **individualised physical activity plan** with Caterina.

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**.

Eleanor (GP) **reviews Caterina's care plan** and notes Caterina's blood glucose levels are outside target range. Eleanor (GP) **adjusts Caterina's current medications, requests updated blood tests** and **arranges a follow-up visit** to monitor progress.

Sparked HL7 FHIR

Caterina's Story – 3



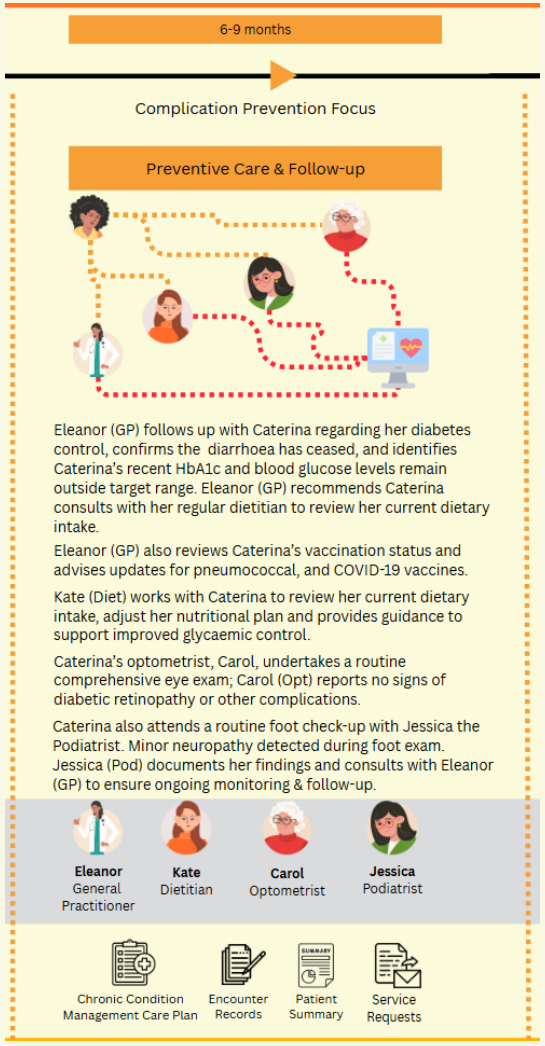
Caterina **presents to Eleanor (GP**) with some **questions regarding her medications**. Caterina reports that she has been **experiencing diarrhoea** when taking metformin and has **stopped using it**.

Cindy (Pharm) 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.

Eleanor (GP) assesses Caterina, checks her recent lab results and reviews her current list of medications. Eleanor (GP) agrees with ceasing Caterina's metformin.

Caterina also meets with **Tim (CDE) who provides additional support and education** to Caterina.

Caterina's Story – 4



Eleanor (GP) follows up with Caterina regarding her diabetes control, **confirms the diarrhoea has ceased, and identifies Caterina's recent HbA1c and blood glucose levels remain outside target range**. Eleanor (GP) recommends Caterina consults with her regular dietitian to review her current dietary intake.

Caterina's optometrist, Carol, undertakes a **routine comprehensive eye exam;** Carol (Opt) reports no signs of diabetic retinopathy or other complications.

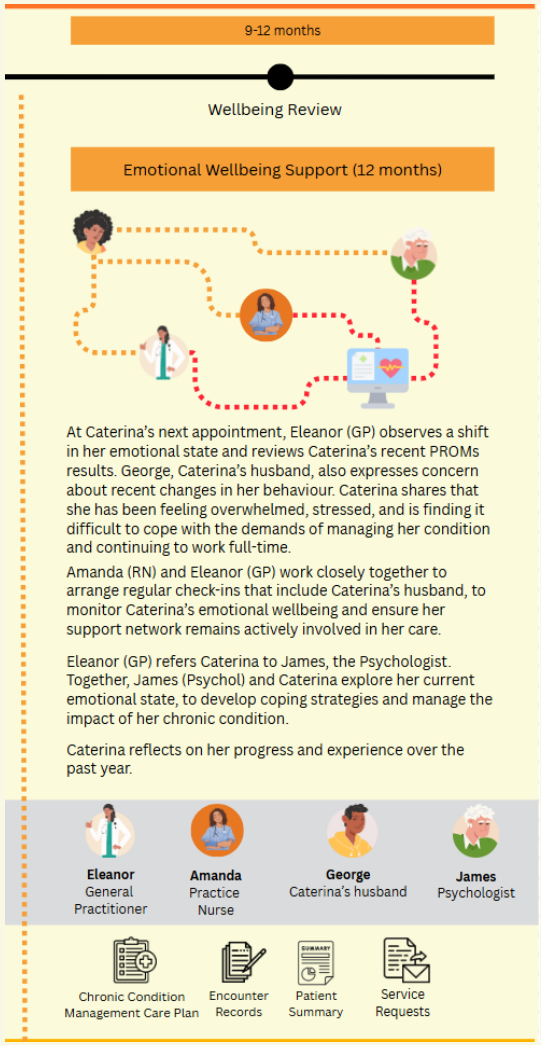
Kate (Diet) works with Caterina to review her current dietary intake, **adjust her nutritional plan** and provides guidance to support improved glycaemic control.

Caterina also attends a **routine foot check-up** with **Jessica the Podiatrist**. Minor neuropathy detected during foot exam. **Jessica (Pod) documents her findings** and consults with Eleanor (GP) to ensure ongoing monitoring & follow-up.

Eleanor (GP) also reviews Caterina's **vaccination status** and advises updates for pneumococcal, and COVID-19 vaccines.

Sparked HL7 FHIR

Caterina's Story – 5



At Caterina's next appointment, **Eleanor (GP) observes a shift in her emotional state** and reviews Caterina's recent PROMs results. **George, Caterina's husband**, 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 and continuing to work full-time**.

Amanda (RN) and Eleanor (GP) work closely together to **arrange regular check-ins** that include Caterina's husband, to monitor Caterina's emotional wellbeing and ensure her **support network remains actively involved in her care**.

Eleanor (GP) refers Caterina to **James, the Psychologist**. Together, James (Psychol) 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.

Sparked HL7 FHIR

Morning tea

Back at 11:00am

Overview of workshops

Workshop 1

MVP

- Understanding clinical and technical requirements for a CCM plan template MVP and workflow mapping

Workshop 2

Roadmap and future state view

- Understanding the desired future state of chronic condition management planning, consumer empowerment and enabling digital infrastructure
- Understanding requirements of the interplay of CCM in the greater ecosystem of patient summary, referrals, encounter record, etc

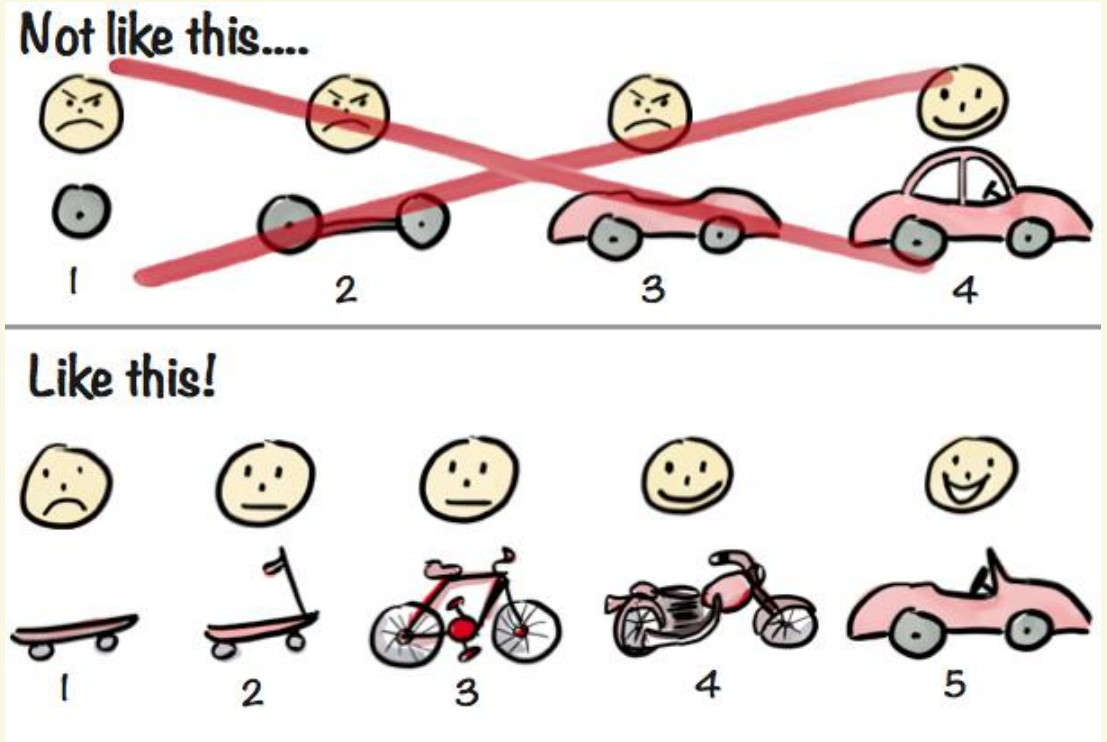
Sparked HL7 FHIR

Workshop 1: MVP for a GP Management Plan

- Commencing with a GP Management Plan template - the MVP needs to
  - Cover the minimal requirements for a GP Management plan which meets the MBS requirements.
  - Noting - Share and view only – no collaboration,
  - Be specified by June 2026 and available for implementation.

What's an MVP for the template?

- A minimum viable product (MVP) is a version of a product with just enough features to be usable
- Focus on a template for a care plan created by the GP (GP management plan)
- Developing MVP in a way that support future enhancements



GPCCMP – Required Contents

1. a written plan for the patient that describes:
   a. the patient's chronic condition and associated health care needs; and
   b. health and lifestyle goals developed by the patient and medical practitioner using a shared decision making approach; and
   c. actions to be taken by the patient; and
   d. treatment and services the patient is likely to need; and
   e. if the patient would benefit from multidisciplinary care to manage the chronic condition, the treatments or services to which the practitioner will refer the patient (including the purposes of those services); and
   f. arrangements to review the plan (including the proposed timeframe for review); and
2. if the patient is to be referred to a member or members of a multidisciplinary team for management of the patient's chronic condition:
   a. obtains the patient's consent to sharing relevant information, including relevant parts of the plan; and
   b. if the patient so consents—provides relevant parts of the plan to the members of the multidisciplinary team; and
3. records the patient's consent and agreement to the preparation of the plan; and
4. offers a copy of the plan to the patient and the patient's carer (if any, and if the practitioner considers it appropriate and the patient agrees); and
5. adds a copy of the plan to the patient's medical records .

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

Eleanor
General Practitioner

Amanda
Practice Nurse

Tim
Credentialled Diabetes Educator (CDE)

Kate
Dietitian

Josh
Exercise Physiologist

Cindy
Pharmacist

Carol
Optometrist

Jessica
Podiatrist

James
Psychologist

Timeframe: 0-1 month

Stage: Diagnosis of Type 2 Diabetes

Activity: Diagnosis & Care Plan Initiation

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

Caterina's General Practitioner, Eleanor, provides an explanation of her condition, initiates a Chronic Condition Management Plan (CCMP), and coordinates referrals to multiple healthcare providers, including a Dietitian, an Exercise Physiologist, an Optometrist and a Podiatrist.
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Tim (CDE) supports Caterina in understanding her diagnosis, managing her diabetes, and monitoring her glucose.

Caterina also discusses her recent diagnosis with her regular pharmacist, Cindy, who offers support and education to help Caterina understand the changes to her medication regimen.

Care team members:

- **Eleanor** General Practitioner
- **Tim** Credentialled Diabetes Educator (CDE)
- **Cindy** Pharmacist

Data & information:

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

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CIAL

Workshop 1: MVP

- What should an MVP for a GP Management Plan template look like, knowing we are building a roadmap to an interoperable, future focused Chronic condition management plan?

Smart Form Demo

Workshop 1

- Activity 1
  - Objective: Explore the process/workflow for the GPMP MVP

- Activity 2
  - Objective: Agree the design principles and design requirements of an MVP GPMP template for delivery in June 2026

Starter principles of GPMP MVP and design/functional requirements

Proposed principles of GPMP MVP	Design/functional requirements	Count
The EMR or clinical system is the source of truth for patient data		6
Launch form from EMR or clinical system within patient record	Launch within context (SMART Launch)	5
Prepopulate form with patient data from EMR or clinical system	Structured patient data should be prepopulated into the GPMP at initial generation i.e. Patient Summary information (SDC Specification, AU Core, AU PS) Where structured data is not yet available, this will remain free text for MVP	9
Write patient data from form back into EMR or clinical system	Writeback to be support for elements aligned with AU Core and AU PS GPMP should be saved be to the EMR or clinical system in a human readable form	1
Standardisation of user experience	GPMP template developed as a FHIR questionnaire, aligned with AU Core, which can be implemented by vendors	3
Output patient friendly version of form	Printable version of the GPMP can be generated	4
Needs to meet MBS requirements for GPMP	Will contain patient summary details, goals, interventions/activities, care team members	9
Digital signature		
Upload to MyHR		
Ability to update information that has been prepopulated from the EMR		
Noted nominated “lead” of the ‘actions’		
Sharing electronically		
Able to differentiate acute and chronic problems		
National services directory		

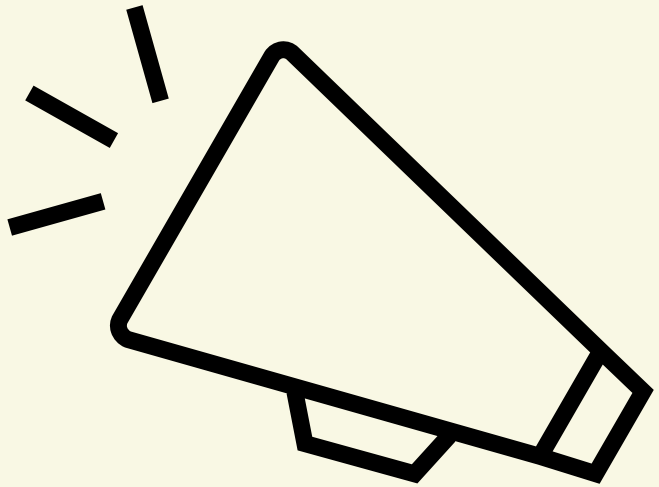
Workshop 1 Activity 1

- Objective: Explore the process/workflow for the GPMP MVP
- As a group, discuss
  - The pain points with using the current GPMP in current workflow
  - In the context of the current GPMP workflow, for each of the workflow steps, what are the requirements that need to be considered as part of MVP (June 2026)
    - clinical requirements
    - technical requirements
    - policy/governance requirements
    - barriers and enablers
  - Where there are relevant specific perspectives, please identify (e.g. GP generating, Physio receiving)

As a **group**
at your table

Report back!

(30 min)



Workshop 1 Activity 2

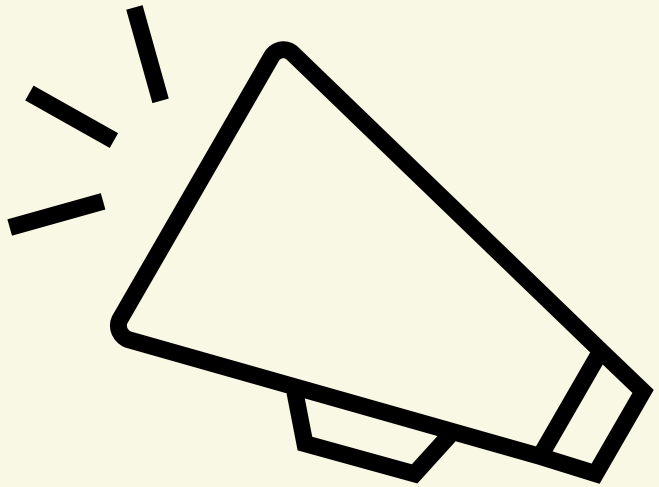
- Objective: Agree the development principles and design requirements of an MVP GPMP template for delivery in June 2026

- As a group, discuss the proposed principles and design requirements in the context of an MVP to be delivered in June 2026.
  - Mark up any changes to the proposed development principles and requirements
  - Add any additional requirements or design principles
  - Agree the 3 non-negotiable development principles for the table and mark on the sheet.

As a **group**
at your table

Report back!

(25 min)



Lunch

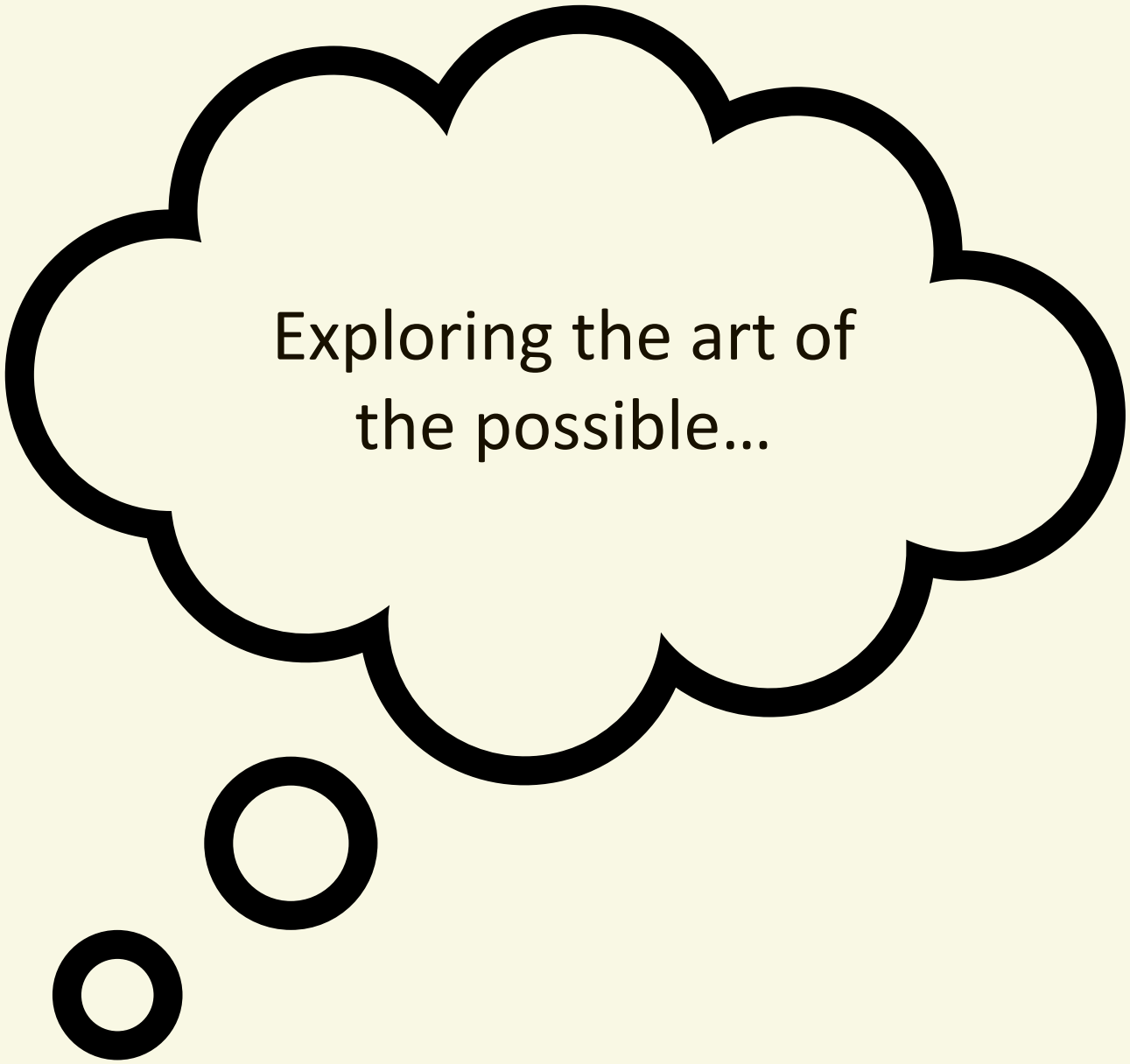
Back at 1:45pm

From MVP to the future

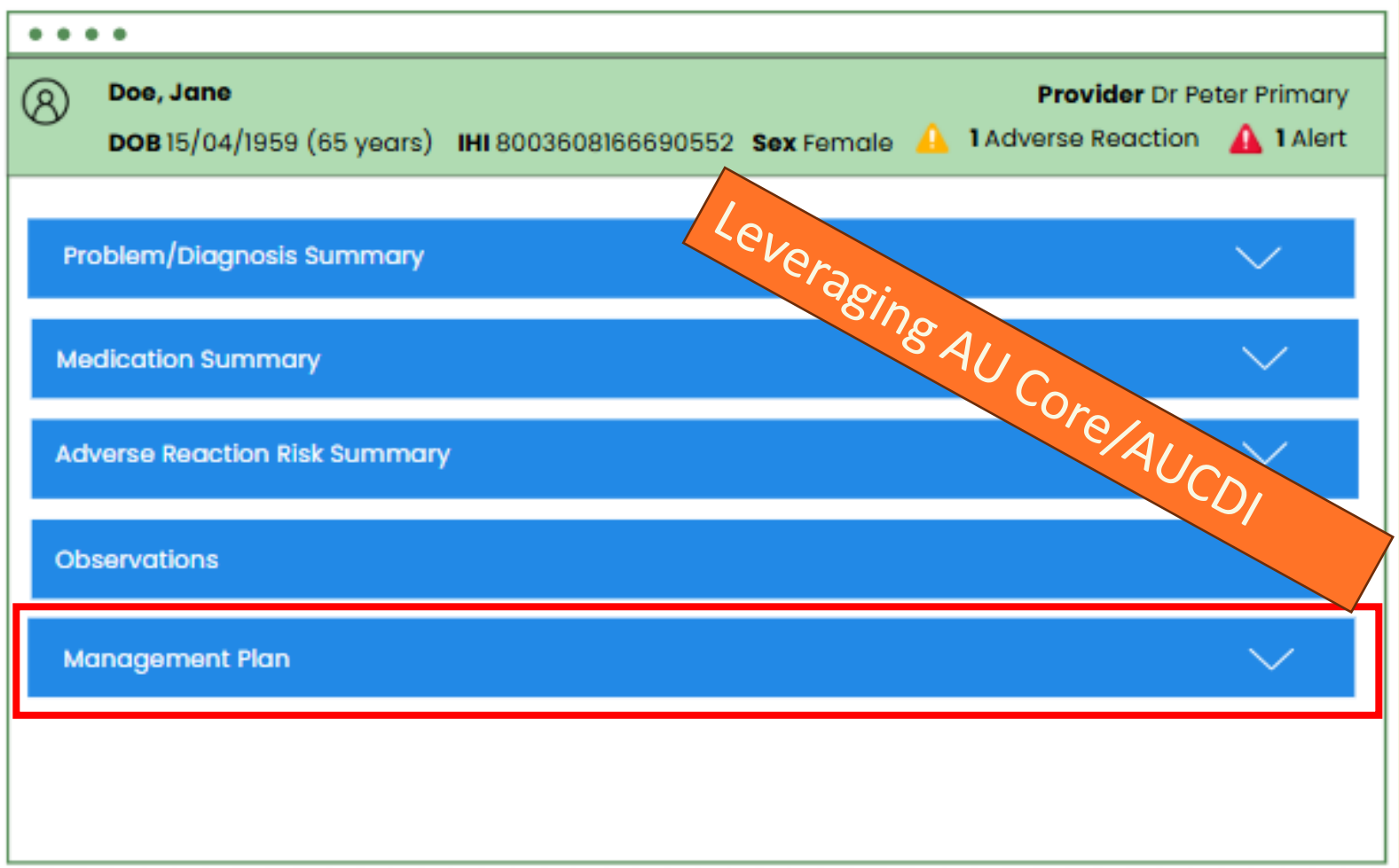
Developing a road map for Chronic Condition Management

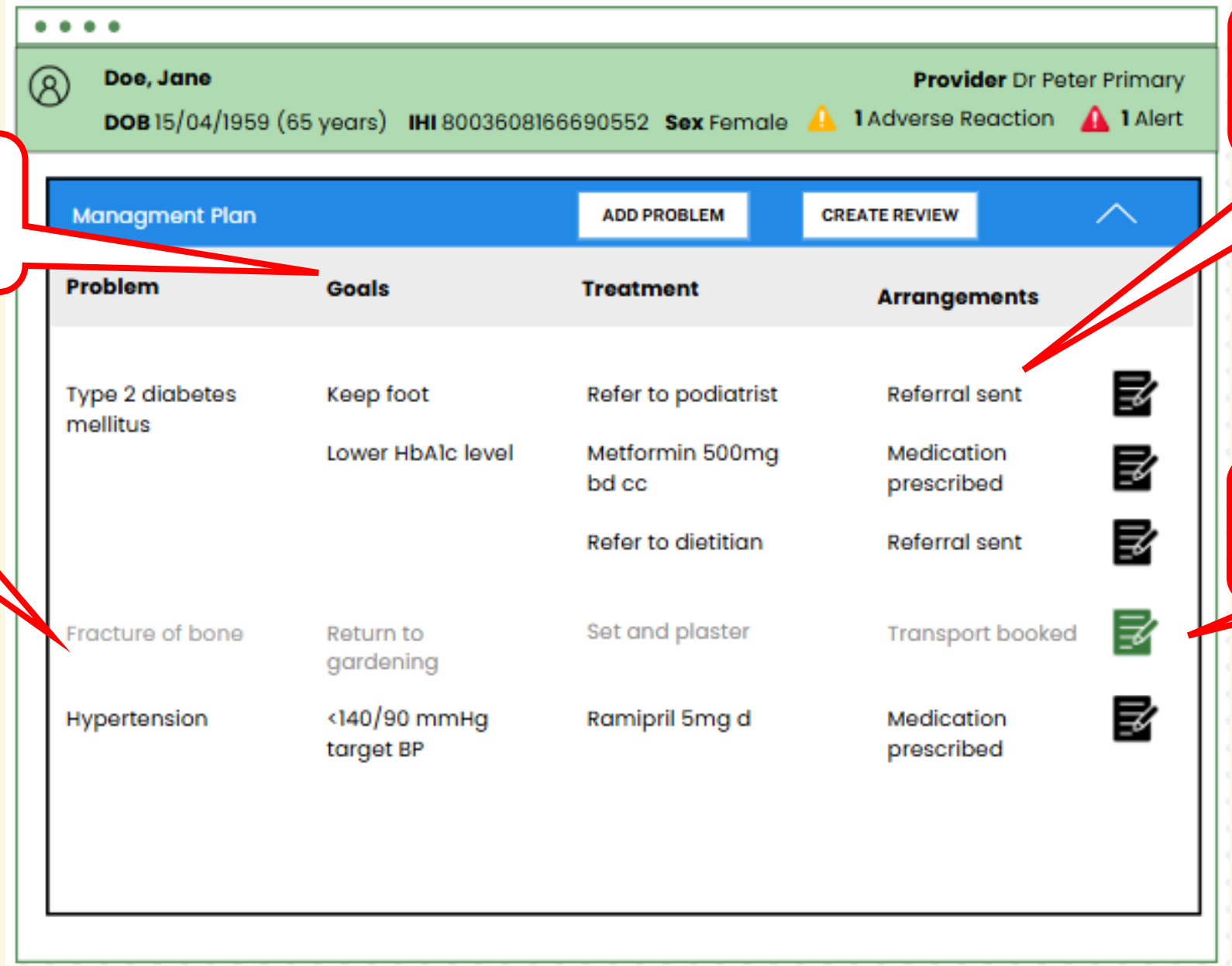
Refocus on the Sparked CCM work done so far before the workshop activities

- Explore the art of what's possible
  - Wireframes of a CCM plan of possibilities
- Recap of Adelaide Chronic Condition Management plan template workshop outputs
- Update of the Chronic Condition Management Clinical Focus Group outputs


Exploring the art of
the possible…

Chronic Condition Management Plans





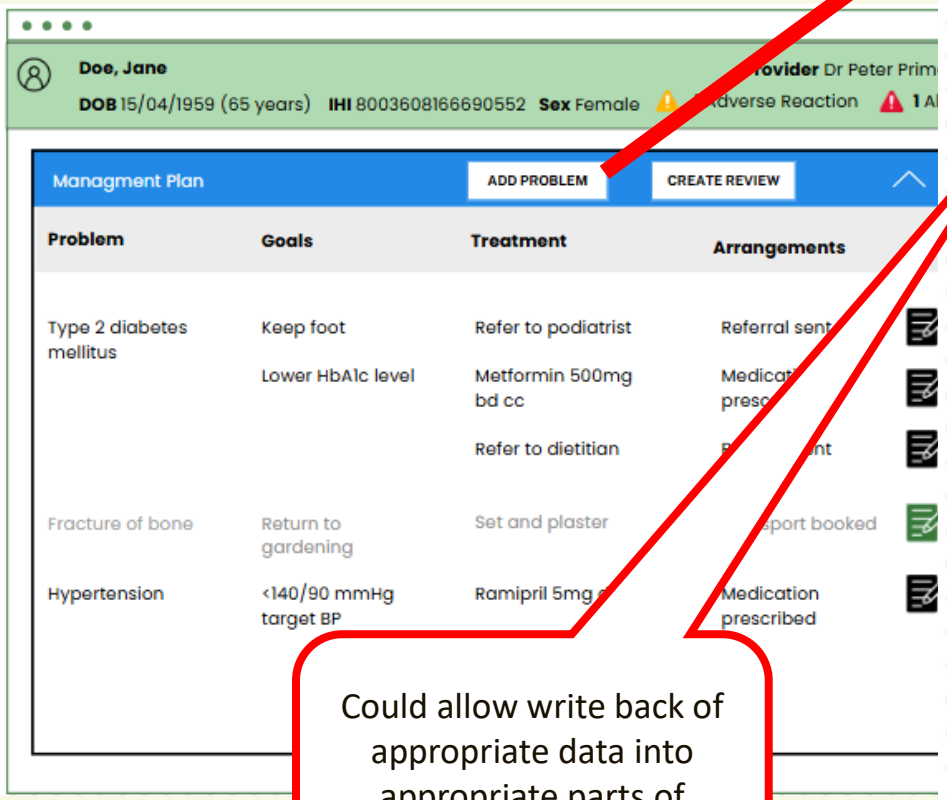
Multiple goals could be assigned per problem

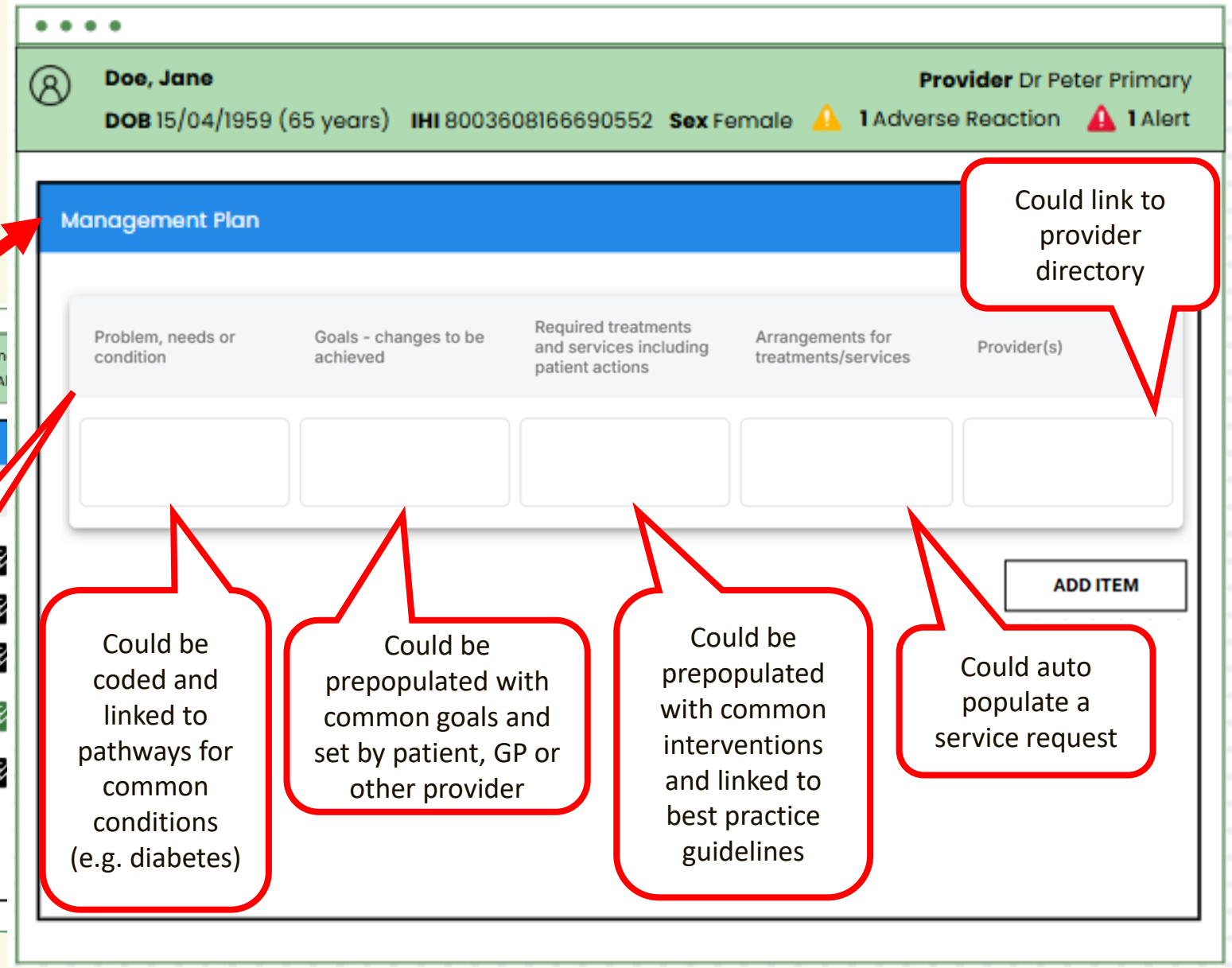
Multiple treatments/interventions or arrangements could be assigned per goal

Problem could be greyed out when resolved/inactive

Form could turn green when goal is reached

Sparked HL7 FHIR





Could link to provider directory

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

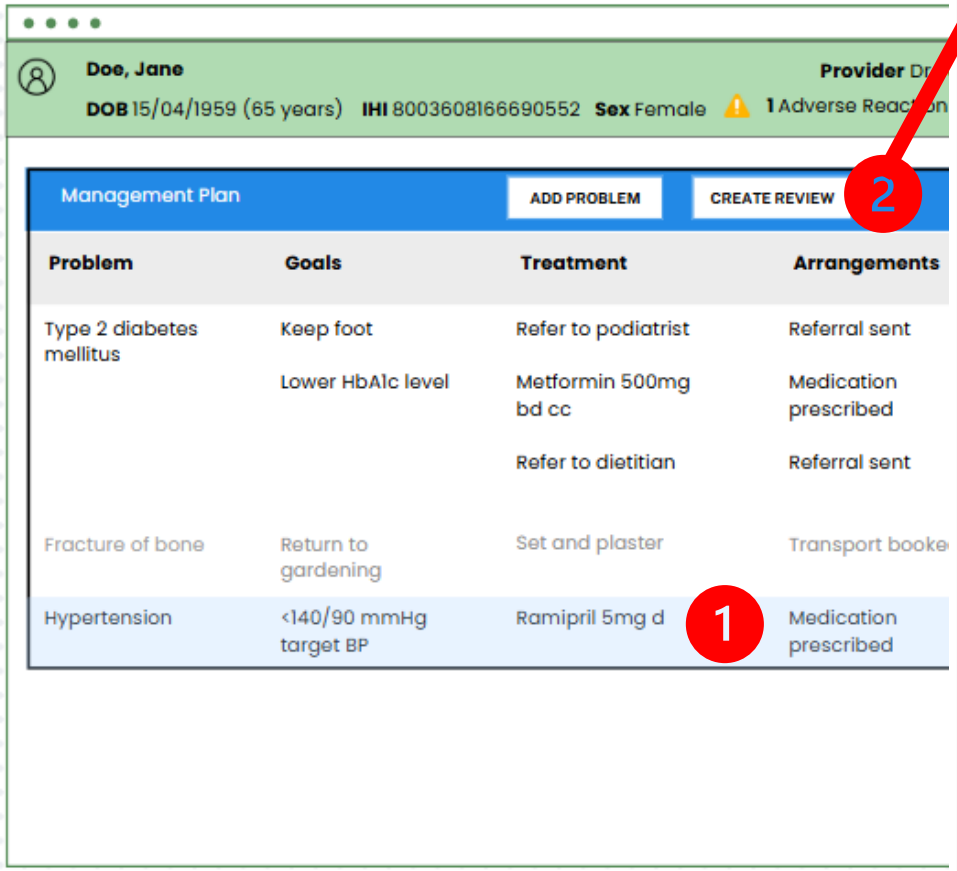
Could be prepopulated with common goals and set by patient, GP or other provider

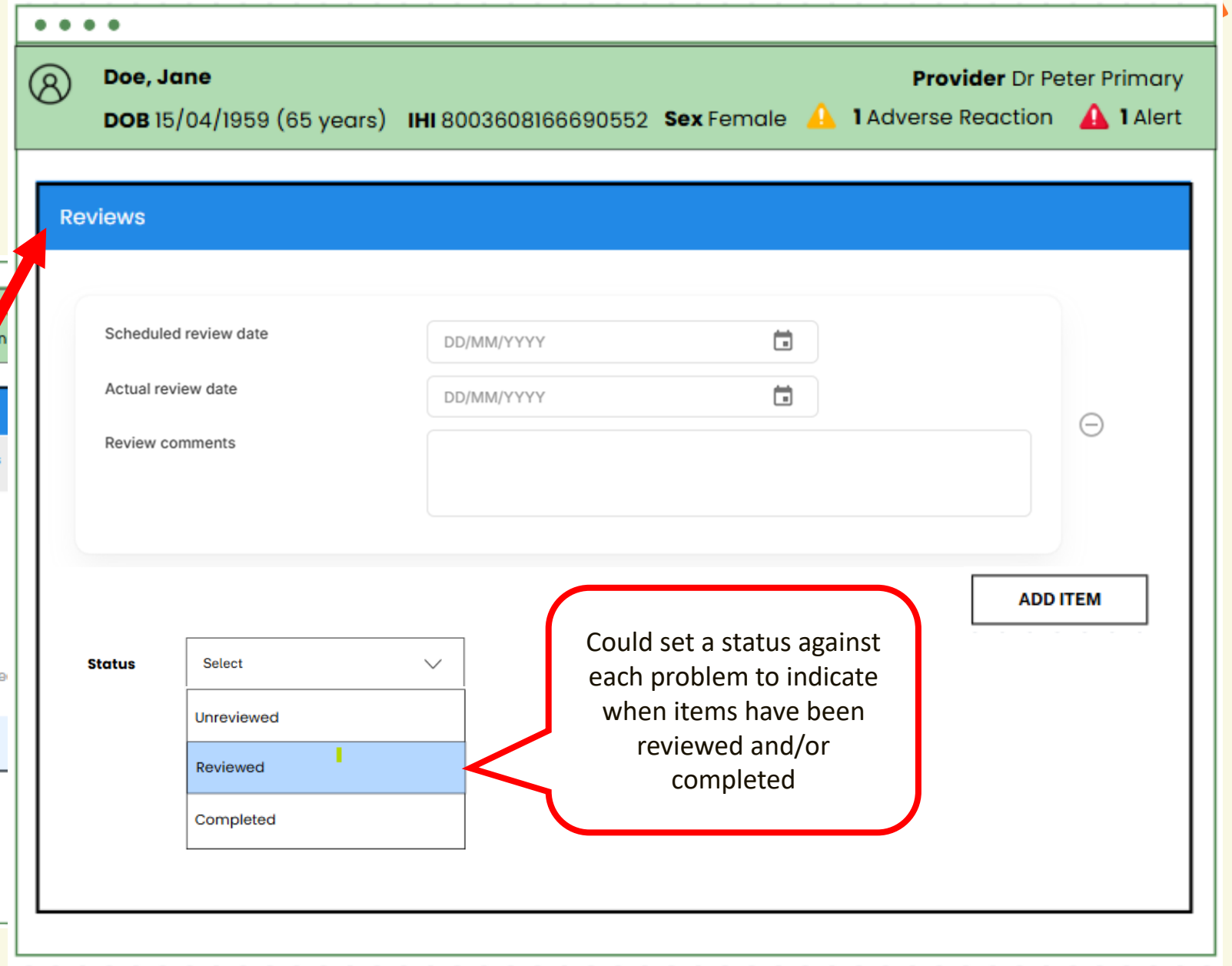
Could be prepopulated with common interventions and linked to best practice guidelines

Could auto populate a service request

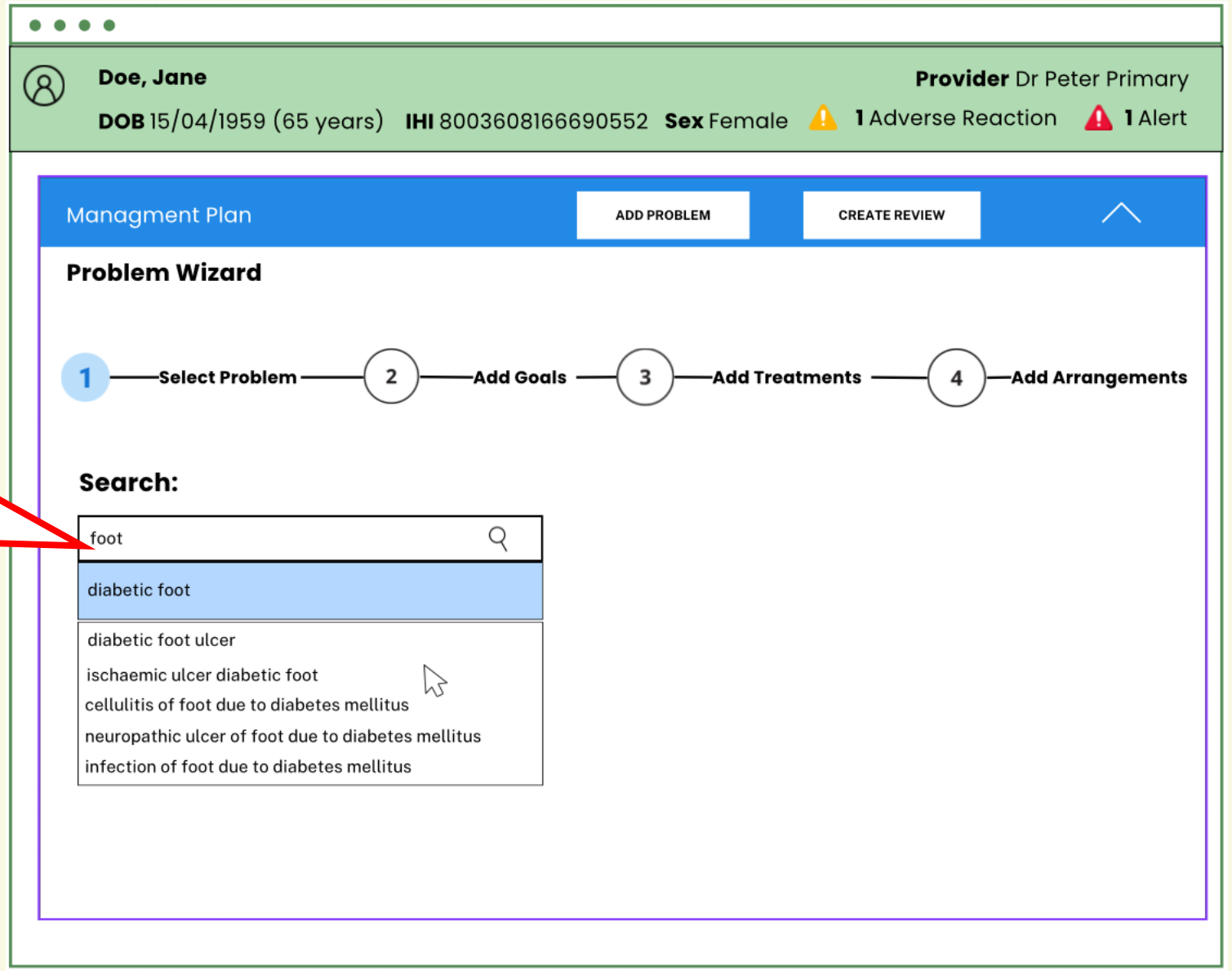
Could allow write back of appropriate data into appropriate parts of structured patient record

Sparked HL7 FHIR


Doe, Jane
DOB 15/04/1959 (65 years) IHI 8003608166690552 Sex Female
1 Adverse Reac
Management Plan
ADD PROBLEM
CREATE REVIEW
Problem
Goals
Treatment
Arrangements
Type 2 diabetes mellitus
Keep foot
Refer to podiatrist
Referral sent
Lower HbA1c level
Metformin 500mg bd cc
Medication prescribed
Refer to dietitian
Referral sent
Fracture of bone
Return to gardening
Set and plaster
Transport booke
Hypertension
<140/90 mmHg target BP
Ramipril 5mg d
Medication prescribed
1
2

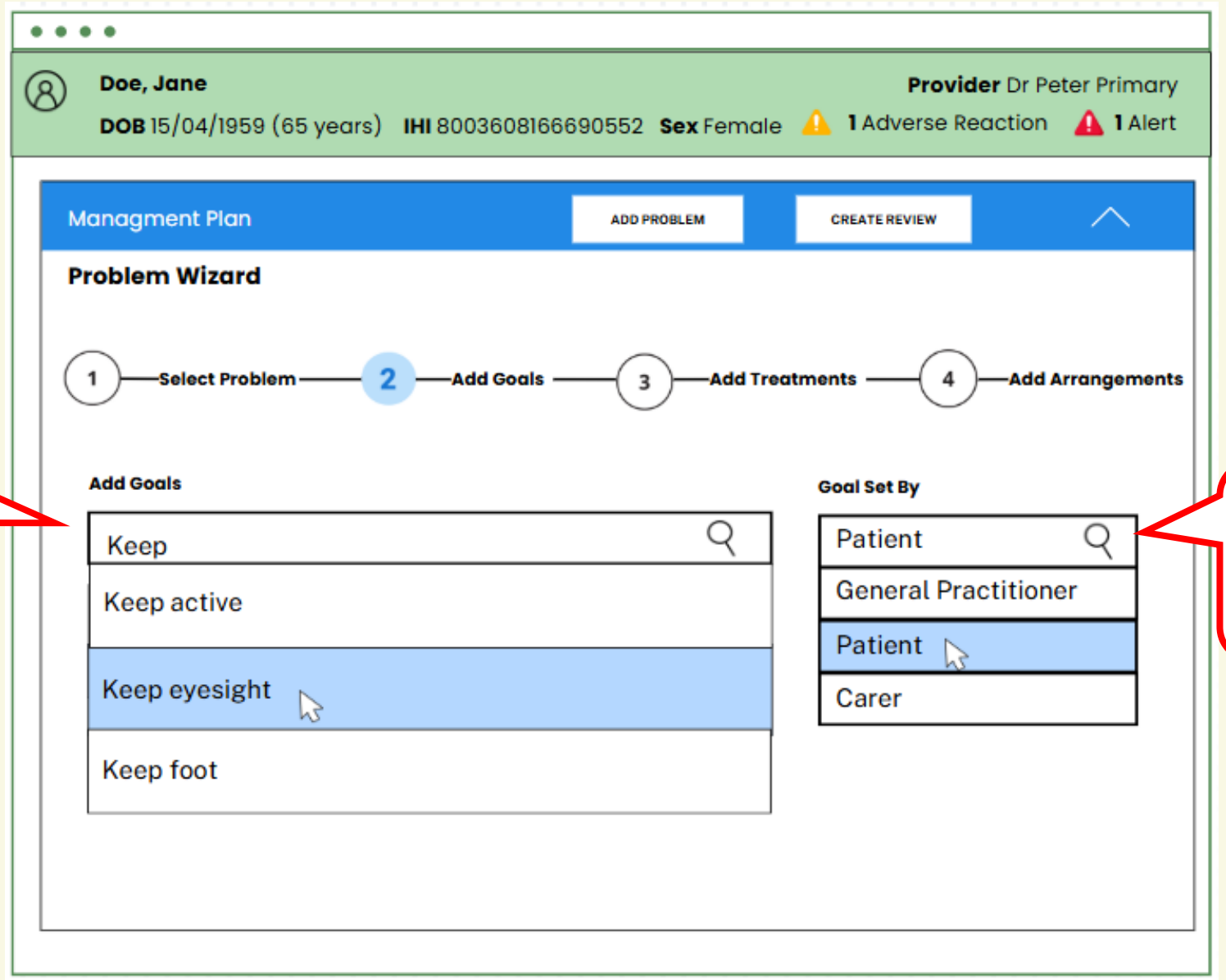

Doe, Jane
DOB 15/04/1959 (65 years) IHI 8003608166690552 Sex Female
1 Adverse Reaction
1 Alert
Provider Dr Peter Primary
Reviews
Scheduled review date
DD/MM/YYYY
Actual review date
DD/MM/YYYY
Review comments
ADD ITEM
Status
Select
Unreviewed
Reviewed
Completed
Could set a status against each problem to indicate when items have been reviewed and/or completed

Problem Wizard Step 1 Add Problem



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

Problem Wizard Step 2 Add Goals

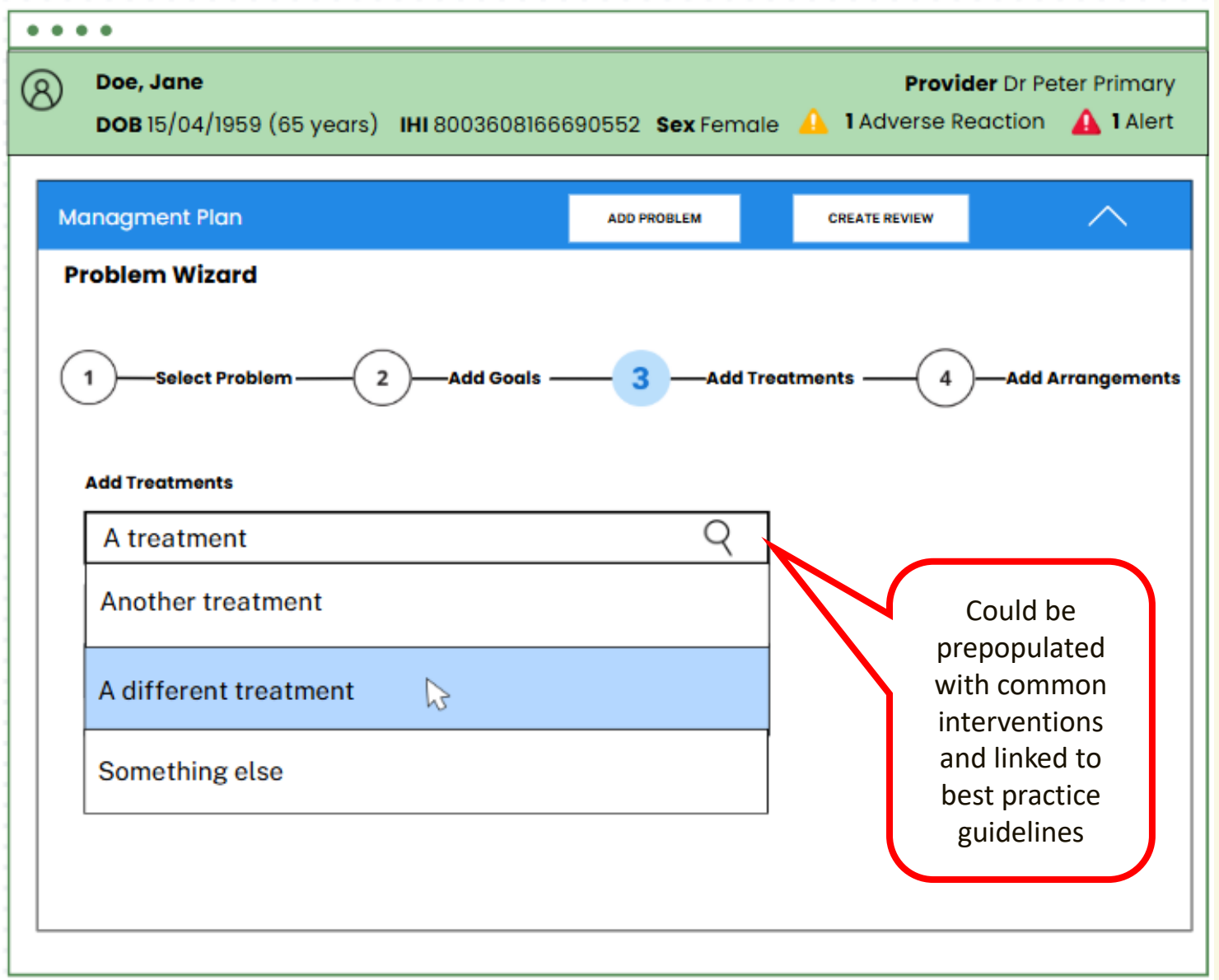


Could be prepopulated with common goals

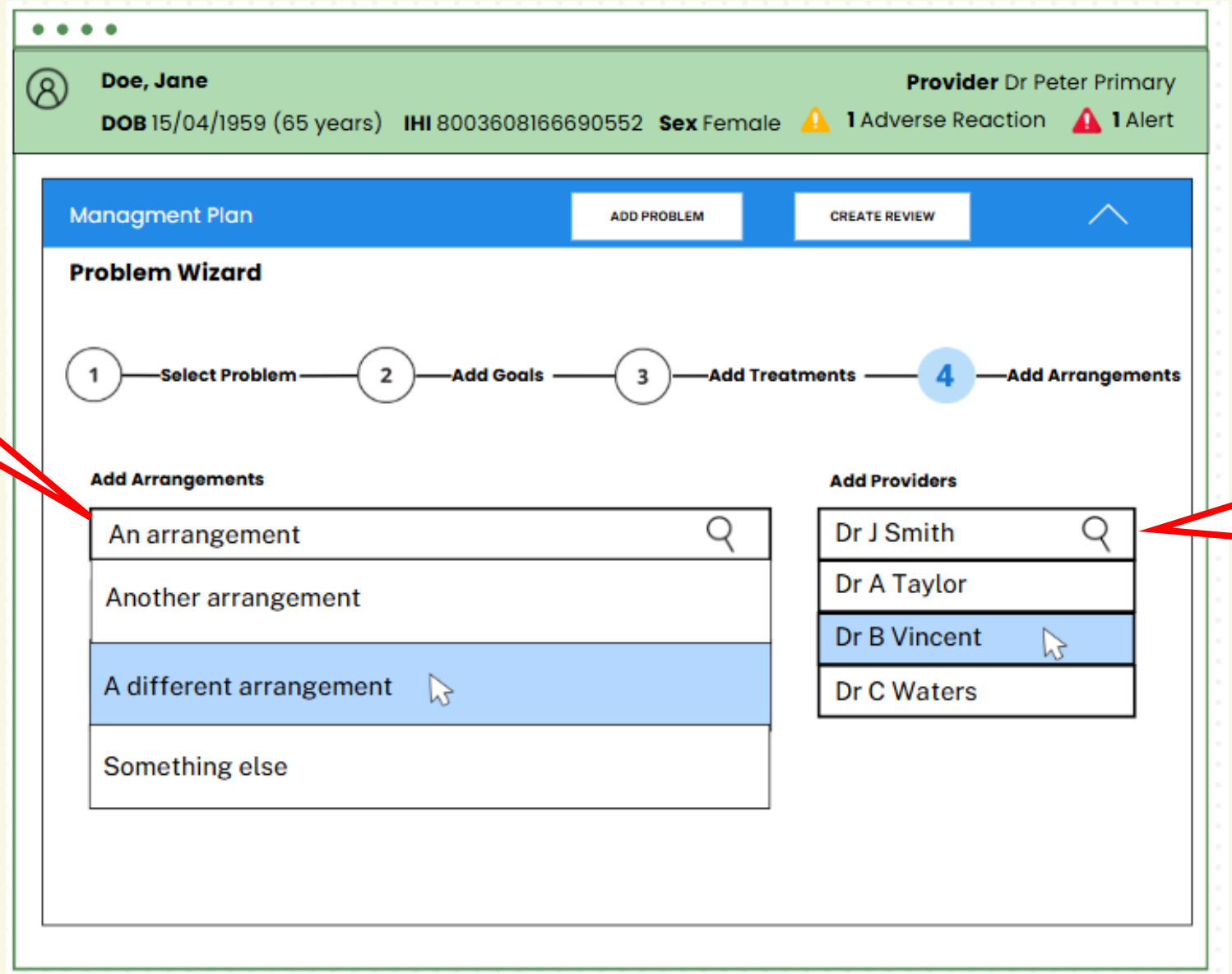
Could be set by GP patient, carer or other provider

Sparked HL7 FHIR

Problem Wizard Step 3 Add Treatment/Intervention



Problem Wizard Step 4 Add Arrangements



Could auto populate a service request

Could link to provider directory

OFFICIAL

CDG- Key usability principles

Access

- Patient access and contribution (e.g. update status of goals)
- Data sharing – Consent, privacy principles
- Carer access and validation
- Dynamic Real-time information transfer/contribution (not a PDF)
- Multi-practitioners able to access and update
- Ensure proper communication between providers and patient
- Integration with practice software

Support team care contributions

- Team members – when joined, left, context
- Multiple contributers from different organisations
- Care team function - roles – owner, contributor, informational
- Support patient self-management
- Irrelevant of eligibility of programs
- Understand why particular pathways were not continued

Traceability of information

- Visibility of source

Visibility/Presentation of information

- Problems/ diagnoses, summary of chronic conditions
- Communication tips for effective outcomes
- Flexibility of retrieving more current information
- Timelines/dates for when conditions occurred/resolved, progress easy to track
- Different views – summary, user based, condition based, customizable

Inclusion of Information (content)

- Free text AND coded information should be allowed
- Prepopulation of relevant ifno
- Goals should be manageable and agreeable
- Health issues – what the patient sees as the current issue
- RAG status – how far along are you
- Updated contact details of all providers
- Wearables data

Use of CDS tools

- Trigger alerts
- Prompt clinicians to ask appropriate questions
- Linking information/ standardized actions against best practice guidelines

Link to Referrals

- Links back to referrals

Sparked HL7 FHIR

CDG- Workflow challenges

Need to form consensus

- Goals
- Updates to care plan

Communication

- Accessibility of care plan
- Ensuring information finds appropriate destination (directory)
- Need for acknowledgement
- Authentication
- Shared view
- Patient admin systems data exchange and sync
- Integration of test and imaging requests, referral workflow
- Provenance of information

Care team

- Lack of provider/Health registry
- Limited widespread formal CCM
- Difficulty of identification of eligible patients for care plan
- Multiple care providers involved
- Need to include patients and carers
- Need for reviews and status updates
- original date goal due, number of revisions and current dates
- Supporting synchronous and asynchronous outcomes and interactions
- Role and accountability
- Funding models

Curation of Patient information

- Maintenance and curation of information/ too much information
- Need a depth of information but then that needs to be curated

Patient

- Readiness of patient to engage in self-management
- Not all have a regular GP
- Currently patient-initiated care not included
- Acceptance/ consent
- Regard patient engagement with activities

Care management

- Limited widespread formal CCM

CDG Outputs- Additional information that should be recorded or additional features

- Priority of conditions (when multiple)
- Funding accessibility
  - Pension/NDIS/Medicare/MBS billing
- Outcomes
  - Measurable outcomes
- Patients
  - health values and prioritisations
  - Preferences, barrier to care
  - SDOH factors
  - Health concerns and problems
  - Self management/empowerment principles/considerations
- Goals
  - SMART formatted
  - Measurable
  - Barriers to achieve
  - Urgency
  - Ownership
  - Timeframes
  - Personal goals/clinical goals
  - Agreement of goals by patient and GP
- Activities
  - Ownership
  - Information re historical interventions/goals
  - Self management/education
- Care team details
- Follow up flags
- Referrral recommendations
  - Noting patient affordability for team and services when may prevent evidence-based goals being included due to non-accessibility
- Integration with
  - Provider registry
  - eRequesting
  - eReferrals
- Updates to the care plan from all involved providers
- Guidelines – easily retrieved or embedded
- Provenance of information
- Control of accessible data - – make the clinically relevant information available to the right team member and the team when they are engaged with care
- Reports/monitoring metrics (patients pov as well)

Sparked HL7 FHIR

CCM CFG Opportunities – ‘Immediate’

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
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
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.
Structured, multi-disciplinary care contributes to quality improvement datasets.
Recent diagnostic results promptly available
Follow-up scheduled.
Changes to Problem/Diagnosis and Medication statement updates CCMP.

CCM CFG Opportunities – ‘Future’

Data and Systems - Future
Ability for Caterina to record her medication usage within the CCMP for visibility to the care team
All members of Caterina’s care team can view and update Caterina’s CCMP
Australian patient summary information is readily accessible to care team members as required
CCMP links to relevant clinical guidelines and clinical decision support tools to assist with evidence-based care planning
Changes to CCMP notifies care team members, tailored by clinical preference or discipline
Clinical decision support recommends best practice medication treatment, relevant diagnostic tests & timeframe to arrange follow-up
Data and Systems - Future
Encounter record information is readily accessible & exchangeable source of data for Australian patient summary information
Pharmacy dispense records available & synchronised with medication information where applicable
Prompts & recommendations for Service Requests, care pathways, service providers, etc. are displayed to CCMP users based on clinical preference or discipline.
Relevant information from existing CCMP is accessible & exchangeable source of information when creating new/additional care plans, e.g. mental health treatment plans
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
When Caterina’s symptoms are recorded in CCMP, clinical decision support recommends medication review, relevant diagnostic tests & timeframe to arrange follow-up

Consolidated feedback – Adelaide CDG and CCM CFG

Enhanced GPMP Smart Form available - which is conformant with AU Core, AU Patient Summary etc

CCMP linked to relevant clinical guidelines and CDS tools

CDS in CCMP pre-population of recommend activities as per clinical guidelines (e.g. service requests, treatment, diagnostic test, follow-ups, timeframes etc)

CCMP generates follow-up flags/prompts back in Source System

Design supports clinical workflow (e.g. condition prioritisation, linkage of related items, RAG indicators)

Consumers can nominate their Care Team within the CCMP

CCMP viewable by all members of care team

CCMP editable by all members of care team

Consumer/carers can view the CCMP

Consumes/carers can update the CCMP (e.g. with personal goals, medication usage etc)

Care team members can subscribe to relevant CCMP notifications

Consumer and/or carer can subscribe to relevant CCMP notifications

Care team members involvement recorded, e.g. when joined/involved, removed, role, function (owner/coordinator, contributor, informational, etc.)

CCMP readily accessible witihn MyHealth Record

CCMP can be readily accessed by Care Team Members

Integration with eReferrals able to generate within the CCM workflow

Integration with eRequesting for diagnostic tests/services able to generate within the CCMP workflow

Supports integration with Provider Directory to identify Care Team Members

CCMP Integrated within EMRs/CISs via SMART

Changes to CCMP writes back & updates EMR/CISs dynamically

EMR/CIS data is accessible and supports pre-population of data within CCMP

AU PS data (via MyHR or HealthConnect) is accessible and supports prepopulation in CCMP use

Relevant CCMP information available to prepopulate new CCMPs

Pharmacy dispense records available to support reconciliation with CCMP medication information

Diagnostic results are available to the entire care team

CCMP Review - Status Indicators to easily identify progress/updates/changes

CCMP support different views, e.g. summary, user based, condition based, customisable

Aligns with AUCDI and supports agreed terminology, noting the need for narrative and free text support.

Supports traceability and provenance of information sources

Supports synchronous and asynchronous outcomes and interactions

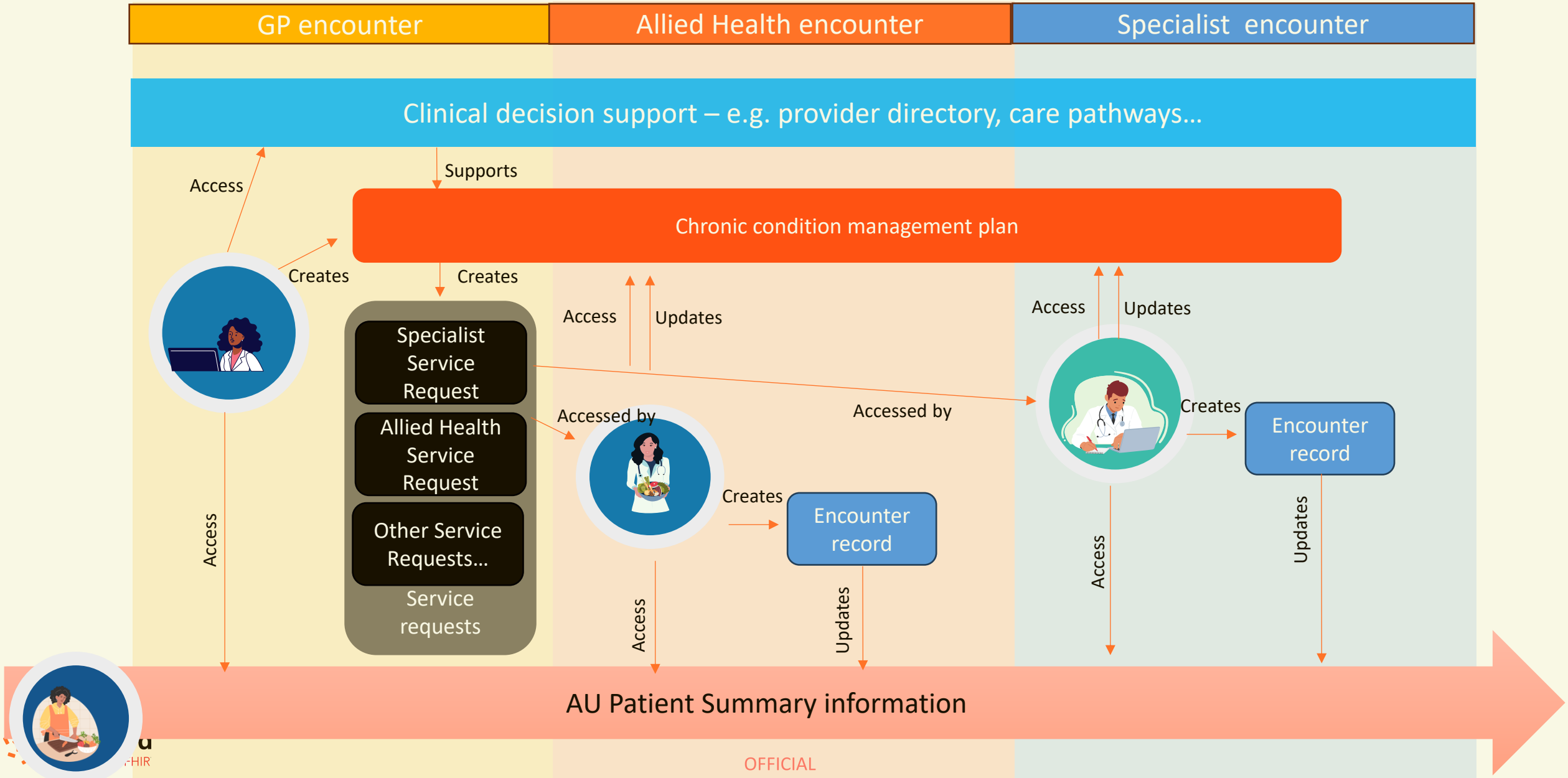
Supports trending data within CCMP over time, e.g. HBA1c , BP, PROMs

Generate reports/monitoring outputs for consumer, carer, clinicians

CCMP supports PROMS

Sparked HL7 FHIR

Consumer journey – CCMP in the ecosystem



Workshop 2 activities

- Activity 1
  - Objectives: Identifying ideal workflow steps and processes and understand clinical/technical features and barriers/challenges.
- Activity 2 and 3
  - Objectives: Build a roadmap for Chronic condition management in the digital health ecosystem

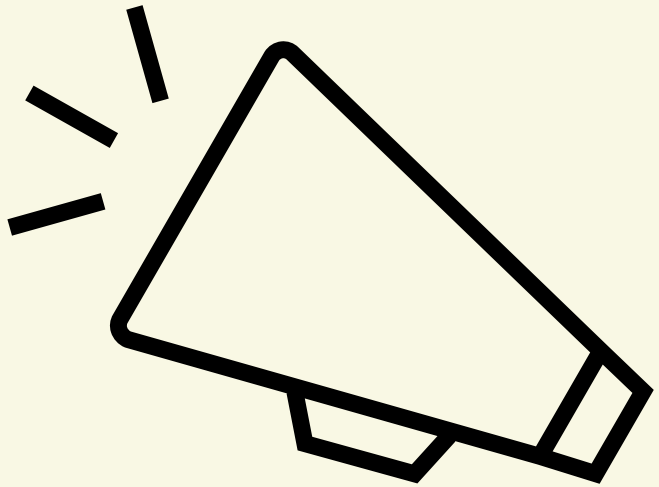
Workshop 2 Activity 1

- Objective: Identifying ideal workflow steps and processes and understand clinical/technical features and barriers/challenges.
- As a group, for the identified clinician/consumer, discuss
  - Identify the ideal workflow steps/processes
  - For each of these steps, what are the
    - clinical requirements/ technical requirements from the list or others!
    - policy/governance requirements
    - barriers

As a **group**
at your table

Report back!

(30 min)



Afternoon tea

Back at 3:30pm

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Generate reports/monitoring outputs for consumer, carer, clinicians

CCMP supports PROMS

Sparked HL7 FHIR

Additional features

#	Additional items
1	Notifications for when changes are made – Updates in real-time
2	Version control – traceability to capture changes
3	Provider directory – include clinician availability, specialty (eg. Dietitian – specialises in eating disorders), qualifications & accreditation
4	Referral status update – know the referral has been actioned
5	Curate what data is shared with who – access & governance of data –
6	Automate/confirm patient eligibility for & status re MBS/funding – My medicare, have sessions left
7	Reminders for follow up
8	Ability to view upcoming appointments
9	Ability to share test, assessment and intervention results
10	Ability to share POC results, wearable data etc
11	Care plan reconciliation
12	Differentiate between acute problems & chronic condition for CP
13	Digital signature

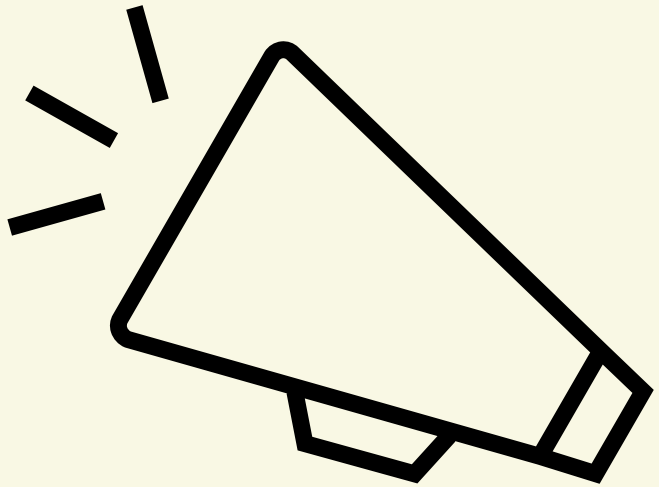
Workshop 2 Activity 2

- Objective: Build a roadmap for Chronic condition management in the digital health ecosystem
- As a group, considering the workflows discussed in activity 1, for each feature identify
  - Next or Future – what is the priority for this feature
  - Pre-requisites/enablers to make this happen
- Add any identified additional features from the previous workshop

As a **group**
at your table

Report back!

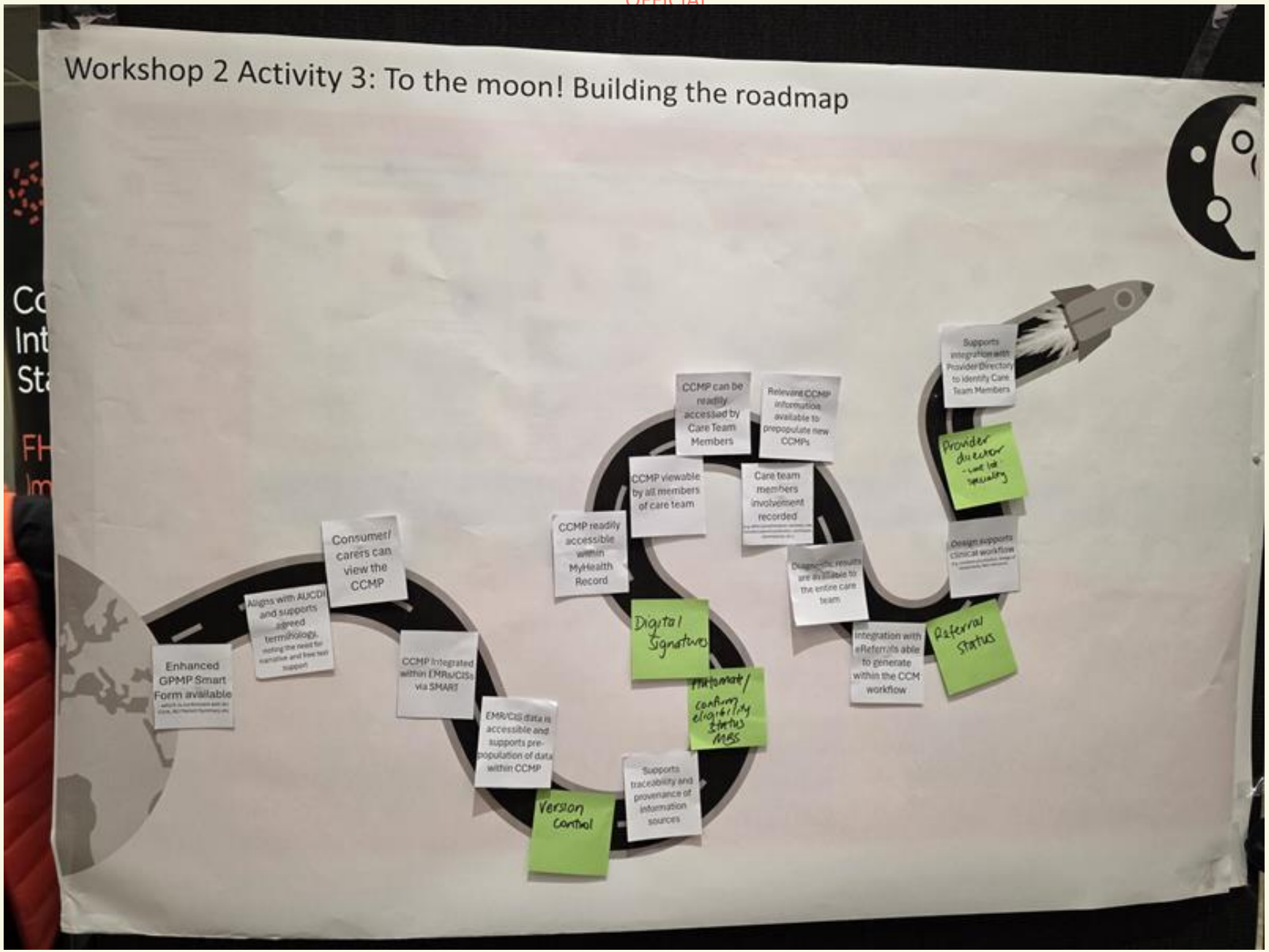
(30 min)



Workshop 2 Activity 3

- Objective: Build a roadmap for Chronic condition management in the digital health ecosystem

- Let’s shoot for the moon and build the roadmap out with features discussed in Activity 2


Workshop 2 Activity 3: To the moon! Building the roadmap
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CCMP readily accessible within MyHealth Record
CCMP viewable by all members of care team
CCMP can be readily accessed by Care Team Members
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Diagnostic results are available to the entire care team
Integration with eReferrals able to generate within the CCM workflow
Referral Status
Design supports clinical workflow
Supports integration with Provider Directory to identify Care Team Members
Provider directory

Next Steps

- Through the CFG develop the next level of details in user workflows and requirements for the GPMP MVP
- Progress to the next stage of the GPMP Template MVP for discussion in November CDG
- Develop a draft CCMP Roadmap for discussion in November CDG

Menti

Register for Sparked

Sparked Podcast

LinkedIn

Website

https://sparked.csiro.au/


Thank you!