

A woman with long dark hair is smiling and looking towards the camera. She is holding a smartphone in her right hand, which has a gold ring on the ring finger. In the background, a young child is visible, also looking towards the camera. The background is slightly blurred, suggesting an indoor setting.

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Advanced digital models of care

phn
WESTERN NSW

An Australian Government Initiative

Advanced digital models of care

Advanced digital models of care refer to healthcare delivery systems that leverage cutting-edge digital technologies like artificial intelligence, remote patient monitoring, wearable devices, and telehealth to provide highly personalised, proactive, and data-driven care.

Essentially, it's about integrating advanced technology to enhance the accessibility and quality of healthcare delivery across various settings.

Key aspects of advanced digital models of care:

Remote patient monitoring:

Continuously tracking vital signs and health metrics through wearable devices or home sensors, allowing healthcare providers to intervene proactively in case of concerning changes. A good example of this is the use of Continuous Glucose Monitoring (CGM) devices to track blood glucose levels in patients diagnosed with Diabetes Mellitus Type 1 or Type 2.

AI-powered diagnostics, decision support and scribing:

Utilising artificial intelligence algorithms to analyze large datasets and assist clinicians with diagnosis, treatment planning, risk prediction and even clinical documentation processes by scribing notes during consultations with patients.

Virtual care consultations utilising real-time diagnostic tools:

Using more advanced digital diagnostic tools during video telehealth consults, provides clinicians with important evidence in real time, assisting the clinical evaluation process.

Personalised electronic shared care planning:

Tailoring treatment plans based on individual patient data and preferences, utilising advanced analytics to identify high-risk populations. Electronic workflow management tools can help to:

- Improve patient referral workflow and ensure GPMs are Medicare-compliant
- Improve patient engagement in the management of their care by giving them access via patient portal. Patients can access their medical records, communicate with providers, schedule appointments, and manage their health information.
- Quickly and securely inform care teams of the current status of a care plan and an Enhanced Primary Care Plan (EPC) referral for allied health partners
- Showcase and capture observations with self-reported measures and remote monitoring.

For more information surrounding AI scribe tools, read the recommendations outlined by the [RACGP here](#)

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Examples of advanced digital models of care:

- **Use of telehealth or AI tool for mental health services:**

Providing therapy sessions via video conferencing or self-service AI tools to improve access to mental health services

- **Precision medicine:**

Utilising genetic data to personalise treatment plans based on individual patient characteristics

- **Incorporating patient experience and outcome measures into everyday care coordination**

Regularly surveying patients about their care experience or outcomes and establishing a longitudinal record of this over the lifetime of care, can potentially provide clinical teams with hidden insights behind patient wellbeing.

Benefits of advanced digital models of care:

- **Improved patient engagement:**

Increased patient involvement in their healthcare decisions through accessible digital tools

- **Enhanced care coordination:**

Streamlined communication between healthcare providers and patients, facilitating better care coordination

- **Cost efficiency:**

Potentially reducing healthcare costs by preventing complications and optimising resource utilisation

- **Access to care:**

Expanding healthcare reach to underserved populations in remote areas

- **Reduce administrative task burden for GPs:**

Potentially saving clinician time by use of AI scribe tools or convenient electronic referral systems

Are there costs involved?

Yes, there may be costs involved with implementing a system and you should seek quotes from a range of reputable vendors. The WNSW PHN, under the Care Partnership – Diabetes Collaborative Commissioning Program, is giving GPs the chance to trial the Inca platform for free till 30 June 2025. GPs that start actively using Inca before 30 June 2025 can benefit from an additional 12 months free licence use to June 2026, but will need to upgrade to Inca EVO during that time period.

When evaluating options, ask the software vendor how they charge for their software:

- Per GP?
- Monthly or annual subscription?
- Bulk clinic discounts?
- Bonus service features such as enhanced training and support?
- Do they charge your team care partners?

Some vendors advertise their pricing on their website. Ask your peers what platform they are using.

Evaluating Shared Care Planning Tools

How can a Shared Care Planning system help you?

While each system will vary in features and usage, fundamentally your chosen system should enable you to automate time-consuming collaborative processes, such as team agreements and follow-up reports, reduce phone tag with care team partners, fax follow-up, and document scanning.

Are these systems optimised for the new Medicare Chronic Disease Management arrangements launched in 2025?

Yes. In fact, most providers of shared care planning systems have been working behind the scenes for sometime, adapting their electronic workflows to make it even easier for clinical teams to hit the ground running on Medicare-compliance. The changes to the GP Chronic Condition Management Plan (GPCCMP) aim to simplify care for patients, encourage ongoing and regular reviews and simplify referral workflows for clinical teams.

Your chosen system should:

- Remove the need for paper-based care plans
- Integrate with your clinical management systems
- Identify goals, targets and actions for your patient

- Enable your patient to easily view and act on their activities
- Enable care team partners to view and accept referrals
- Provide alternate communication methods to phone, fax and email
- Provide reminders and notifications to ensure real-time communication to the care team.

What do I need to set it up?

Many systems are web based so in theory, a good internet connection and your device of choice should get you connected. Ask your vendor what they recommend in way of minimum hardware or software for accessing their system.

What should I do next?

- Ask your peers what system they are using and consider the pros and cons
- Investigate the vendors below to find the one that best suits your needs and budget
- Request a demonstration from the vendors
- Seek quotes from several vendors.

Electronic Shared Care Planning Systems*

[Inca EVO](#) (previously known as Inca and before that cdmNet)

[CareMonitor](#) – Caremonitor Pty Ltd

[Alcidion](#) (Miya Care)

[MyGPMTool](#)

*Inca and CareMonitor products were used in the Healthcare Homes trial. Inca Classic was offered to practices across WNSW PHN area as part of the Care Partnership – Diabetes program between 2021 to 2025.



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