PracSavvy

Clinical Systems Support and Training

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June 2018 — Newsbrief

MyHR

There was a fair bit happening in May, with possibly the biggest news being the announcement of the MyHR Opt-Out period. This had been foreshadowed for a while, so it was nice to finally get some specific information around this.

In a nutshell, the Opt-Out period will be 3 months dating from July 16th and ending on October 15th. After this, there will be another 30 days which will be used by the commonwealth to ensure that it has received and implemented any Opt-Out requests. After this, everybody who has not opted out will have an available My Health Record, (MyHR) that will be activated fully the first time a clinician or the patient tries to access it. During the 3 month phase there will be a significant media campaign alerting the general public to what they need to do if they don't want to participate. Irrespective of this period, it remains the case that an individual can opt in or out of the MyHR system at any point in time.

You can read the full media release here. There will of course be no practice clinical data in a patient's MyHR until the practice uploads a Shared Health Summary. If the auto-activation of the record doesn't make sense to you, it may be time to revisit your understanding of the system, there are plenty of ways you can do this, and I'm happy to come and talk to practice groups if they want a refresher session.

Whilst not wanting to sound like a broken record/scratched CD/corrupted media file, I would encourage practices to look beyond the shared health summary quota and embrace the system and the benefits to the patient when dealing with a *non-familiar* clinician.

Some examples this month of where *better access* to information *may* have created a better outcome. None of them are classic examples, but they illustrate the need to better share information.

Example 1: This Victorian coroners report got a good run in publications recently. In a nutshell a Hodgkins Lymphoma patient was experiencing a toxic reaction to the chemotherapy he was being given. The requested pathology test confirmed this and the result was faxed to the specialist who never received it. Two days after the investigation the patient had another round of chemo and subsequently died alone and unsupported in the hotel he was staying at whilst travelling for treatment.

The coroner quite rightly slammed the reliance on fax machines for an issue of this importance. Even if the fax had been sent to the right number, the actual machine was several floors away from the specialists office and shared between 20 other specialties. What could go wrong ! Whilst there no definitive answer to this, I think it's fair to say that were this specialist participating in an electronic message delivery system, the chances of him or someone reading it in a timely fashion would certainly be far greater. Of course it remains true that when something is extremely urgent, nothing beats picking up the phone.

Example 2: The tragic case of a teenage suicide in Melbourne. In summary, 18 year old Rani, was admitted to a hospital in Melbourne on February 15th after a suicide attempt. On the 18th she discharged herself, but on the 21st she was found wandering in a distressed state and taken to another Melbourne hospital. She chose not to admit and discharged herself. The next day she was found deceased in a city parking lot. Her devastated mother rightly questioned why the 2nd hospital was not aware of her daughters medical circumstances. On the "plus side", Rani's privacy wasn't compromised !

In a world where we take advantage of systems and technology that *are readily available to us*, the 2nd Hospital clinicians access Rani's MyHR and read a summary of her health history. They also read the uploaded discharge summary from the 1st hospital, and possibly refuse to let her discharge this time.

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MyHR

Continued..

Because that's the beauty of the MyHR. You often don't know which medical facility your patient will be dealing with tomorrow, or next week, or next month. What you can do is make key information available to anyone appropriate that needs it. *I realise this piece is very "opinion heavy", but the idea that people should be persuaded that immaculate privacy is more important that well informed and therefore timely healthcare annoys me greatly*.

Example 3: Closer to home, and on a thankfully lighter note, a friend took her 18 year old son to see a local skin specialist. The specialist raised eyebrows at the mother wanting to be in on the consultation, and made comment on it. Halfway through the 20 minute consultation it became obvious that the specialist thought the patient was 28 and not 18, due to either a mistake or misreading of the *handwritten* referral letter. It explained the quick dismissal of the mother's query around whether her son would "grow out of" the complaint. The discovery of the patient's correct age at the half-way mark of the consultation, did not change the strategy suggested by the specialist at all. This was probably absolutely fine, but did leave the mother feeling a little less confident about the advice than she may ordinarily have been.

The other interesting moment came when the patient was asked if he was on any medications, to which he replied "No" The mother quickly corrected him with a reminder of his anxiety medication. Now even reluctant GPs have acknowledged the benefit of the MyHR for the aged and infirm. Should we also acknowledge that there may be other groups that sometimes don't accurately convey their health information. Without wishing to succumb to generalisations, there may be a demographic that don't necessarily give their full attention to queries that don't come to them via a hand-held LCD screen.

eReferral

Please note the following ereferral additions.

New

Dr Lea-Anne May	Rheumatology and General Physician	*hcardiol*

Templates

The following new templates were created during the previous month and are available at my website here:

- Asthma Foundation - Patient Education Referral
- Huon Valley Multi Service Referral (Updated)
- Sleep Better Again Referral (North)

If you need any assistance importing or would like other templates created, please let me know.

Bits

If you feel like some light reading, NPS Medicinewise in conjunction with the Consumers Health Forum of Australia have released have released their report on *Engaging consumers in their health data journey.* You can download the report here.

Hotdoc have also released their Practice Patient Communication survey report, which can be downloaded via this link.

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MD

Ereferral has been a hot topic for me in the last few weeks, with a definite surge in GP interest. With that in mind I've put together some useful bits and pieces.

Selection: It's been mentioned that in MD, GPs at the beginning of the referral creation process have no way of knowing which specialists are electronically referrable. Unlike Best Practice, the selection view of the address book doesn't show you who is enabled. When you go to send the document, you can certainly tell, but not at the beginning.

Practices may want to work around this by flagging all enabled GPs with some sort of indicator after their name. In the example shown below, I have edited the address book and put *** after the surname of enabled specialists.

Select Addressee

Surname: Category: Nephrology.

Address Book

Looking for the right specialist? Free Refer tool in your Sidebar
A comprehensive directory listing sub-specialties and special interest areas
LEARN MOR

All People Companies

Name	Category	Address	Suburb	Postcode
JOSE, Mathew	Nephrology.	Hobart Private Hospital - Suite 5, GPO Box 2173	HOBART	7001
YEW, Steven	Nephrology.	Hobart Private Hospital - Suite 5, GPO Box 2173	HOBART	7001
KIRKLAND ***, Geoff	Nephrology.	Hobart, Tasmania	HOBART	0

The *** will also print on the letter, but you could easily delete this if it bothered you, or you could attach the flag to the suburb field.

Confirmation: The information contained under *Tools..MDExchange..Sent Items*, and the equivalent tab in the patient record give good information on the journey and hopeful eventual acceptance of the electronic document.

MDExchange Outbox

All Messages | Last Month | All Recipients | Dr A Practitioner | All Patients

To	From	Patient	Subject	Sent	Status	Sender
Geoff Kirkland's Surgery	Dr A Practitioner	MR DAVID ANDERSON	MR DAVID ANDERSON	21/05/2018 3:20 PM	Transferred to HealthLink	Dr A Practitioner
Launceston Medical Centre Pty Ltd	Dr A Practitioner	MR DAVID ANDERSON	MR DAVID ANDERSON - Test Only	22/05/2018 3:03 PM	Accepted	Dr A Practitioner
Hobart Cardiology Unti Trust	Dr A Practitioner	JANET BADCOCK	JANET BADCOCK	22/05/2018 4:50 PM	Accepted	Dr A Practitioner
Frank Kimble	Dr A Practitioner	JANET BADCOCK	JANET BADCOCK	22/05/2018 4:53 PM	Accepted	Dr A Practitioner
City Mill Services P/L	Dr A Practitioner	JANET BADCOCK	JANET BADCOCK	22/05/2018 4:55 PM	Transferred to HealthLink	Dr A Practitioner
Launceston Heart Centre	Dr A Practitioner	JANET BADCOCK	JANET BADCOCK	22/05/2018 4:58 PM	Accepted	Dr A Practitioner

Displaying 6 of 241 messages

The *Status* column reflects the progression of the document, with successful ones eventually showing as *Accepted* or *Read* . The *"Transferred to Healthink"* status is an intermediate one, but in some cases is the final one that you will receive. This is because the hidden confirmation messages that are returned from some specialist software programs are not being understood by the MDExchange tool that MD provides. This is true in the case of specialists using the Audit4 and VIP programs. In Tasmania, this means the 2 big Rheumatology practices as well as Tasmanian Eye Clinics.

I have raised this issue with MD, but their response leads me to believe that this will not be fixed any time soon. Note that messages with these practices are working fine, you just don't get to see the nice on-screen confirmation of the fact.

Ideally the Sent Items screen depicted above should be monitored by practice admin staff on a regular basis.

MD

Continued..

Storage: Whether your documents and letters are received electronically or scanned, occasionally there will be information missing from the columns displayed in your clinical record. Note that this doesn't apply to the body of the document, but can make it harder when you are scanning the list, looking for something.

The issue was covered in detail in my November newsletter, but it's worth mentioning the key details again. Bearing in mind that you can drag the column headers around in your document screens (MD will remember your choices), the illustration below shows my thinking for what order the columns should appear in.

Date Created	Date Collected	Subject	Sender/Provider	Description
24/10/2017		RSD - Correspondence	Dr A Practitioner	letter
24/10/2017		RSD - Correspondence	Dr A Practitioner	Referal Letter
22/05/2017	22/05/2017	RSD - General Referral	DR Frederick Findacure	Letter
22/05/2017	22/05/2017	RSD - General Referral	DR Frederick Findacure	
22/05/2017	22/05/2017	RSD - General Referral	DR Frederick Findacure	
22/05/2017	22/05/2017	RSD - General Referral	DR Frederick Findacure	
27/10/2016		RSD - Correspondence	Dr A Practitioner	

Date Created - This date is actually the date that MD imported the document, and as such won't ever be blank. Having this as the first sorting field fixes the fact that some letters come in with a blank *Date Collected* field, which results in the document being sorted incorrectly.

Subject - Useful for scanned documents in that this field can contain the senders name. (Scanned documents do not provide for information in the *Sender* Field)

Sender/Provider - This is useful for indicating the nature of electronically received documents, as they will often have nothing meaningful in the *Subject* field, e.g. "RSD-Correspondence". Seeing a specialist's name in this column will most likely inform you as to what sort of document it is, even if the *Subject* field is unhelpful.

Description - Rounding out the most useful fields, this field must have something in it in order for it to be available as an attachment option for another document (see next section).

Taking the time to set columns up in this fashion should make perusing the document list far more efficient.

Attachment: The question comes up, "can I attach other letters to my ereferrals?" The answer is yes, sometimes. The option that let's you select pathology attachments also scans the documents section of the record.

You certainly can't attach scanned documents, but you will often be able to select a text document for attachment, as long as it has something in the *Description* field (see above). I say often, because sometimes I have seen a document not show in the selection screen, despite the above circumstances being present.

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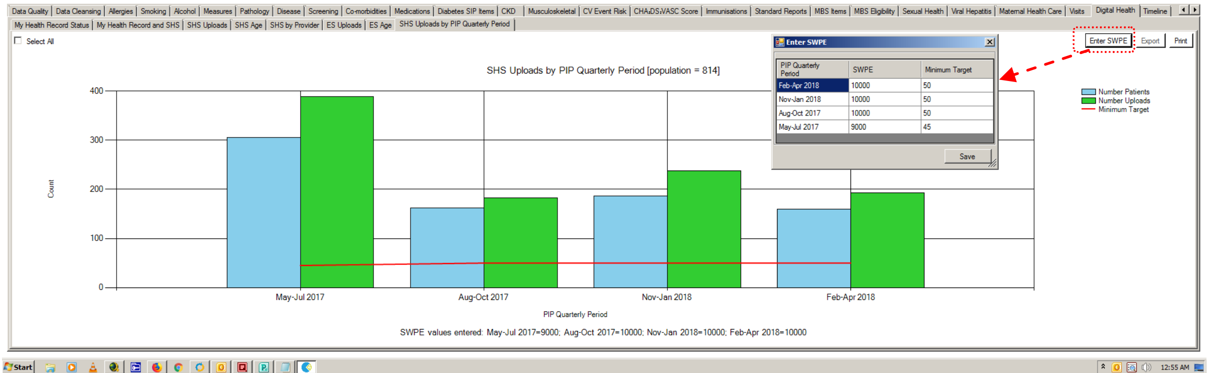
PenCat

The May update for the PenCat tool contained some useful new functionality. The first thing to talk about is found under the Digital Health tab, namely a new sub-tab that depicts Shared Health Summary (SHS) uploads by quarterly PiP periods.



You have the ability to key your SWPE number into PenCat now, with the tool then calculating your target and indicating it via the red line on the graph. The graph shows the last four PIP quarters and purportedly shows both the number of patients with an SHS uploaded and also separately the number of uploads.

Incidentally the list of patient names behind the 2 columns is identical, with Pen doing some tricks behind the scenes so that the green graph at least numerically reflects the number of uploads. For example in the picture above taken from a sample database, the green column in the Jan 2018 quarter reaches well above 200 mark, yet the patient list attached to it says 187 patients. (I suspect my noticing this may cause unnecessary confusion, so just focus on getting the green column above the red line, and all will be fine)

Under the *Conditions* filters, there are now filters for Renal impairment, Kidney Transplant and Dialysis.

Clear Filters
Recalculate
Renal Impairment
Yes
No
Chronic Renal Failure
No
Acute Renal Failure
No
Dialysis
No
Kidney Transplant
No
Clear Conditions

Under *Medications* there are new filters pertaining to anti-diabetic oral or injectable medications.

General | Ethnicity | Conditions | Medications | Date Range (Results) | Date Range (Visits) | Patient Name | Patient Status | Providers | Risk Factors | Saved Filters
Medications - Heart | Medications - Respiratory | Medication - Antidiabetics | Medications - Other

Oral Hypoglycaemics
Yes
No
Alpha-Glucosidase Inhibitor
No
Metformin (Biguanide)
No
Sulfonylurea
No
Glitazone
No
DPP-4 Inhibitor
No
SGLT-2 Inhibitor
No

Injectable
Yes
No
Insulin
No
GLP-1 Agonist
No
Oral or Injectables

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