PracSavvy

Clinical Systems Support and Training

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Edition 99 - November 2024

So it's been a bit of a give and take back month in General Practice, at least as far as software and Medicare Governance go. We know that the Medicare simplification of care planning has been back to July 2025. What people may have missed (well at least I did) was that the restriction on care planning for MyMedicare (MM) registered patients has been put back to that time as well. Remembering that 1/11 was supposed to herald in the fact that care planning for MM registered patients could only be done by their registered practice.

So basically until 1/7/25 the only benefit for practices for registered patients is access to a couple of longer telephone consult items. Given administrative overhead in processing registrations coupled with un-certainty from Medicare staff about how the program works, we are currently firmly in negative territory in terms of benefits for this initiative. Admittedly for some practices the picture **may** be improved by the GPIAC add-on to the scheme.

On a related note the health minister Mark Butler gave a speech recently that I thought was worth ~~tearing to shreds~~ commenting on. As usual the MyHR was a favourite whipping ~~boy~~ person (there's a down side to equality!) Lowlights and comments below.

In the most recent Health of the Nation survey by the Royal College of General Practitioners, 31% of GPs said they rarely, or never, use My Health Record.

Even fewer specialists use it: half of them haven't even registered with it.

Not sure that flagging that 69% of GPs do use a system is a great indicator that it's a bad system. Could it be a minority GP resistance and/or training issue? If specialists aren't using it (which I don't doubt), could it be that to my knowledge there has never been any federal initiative what so ever to reach out to this group and educate them or sell them on the benefits. If the benefit to them directly isn't obvious or significant, then some effort has to be expended to highlight the "greater good" and get them on-board.

It's actually appropriate that Specialists were a low priority for targeting compared to other clinician groups though. Mr Butler and the RACGP would do well to remember that the prime intended beneficiaries of the MyHR were the non-usual clinicians, most specifically emergency room doctors who were encountering patient's they basically knew "jack" about. I can absolutely confirm that I train lots of Reg 1's and interns and they all know about the MyHR through their hospital interface and **are almost universally very grateful for it's existence**. I can think of only 1 conversation I've had that contradicts this and I've had lots of these conversations.

Dr Ramya Raman explained to me how frustrating using My Health Record can be, as a GP.

She said - quote - "Every blood test is a separate file. Every scan is a separate file. They're just labelled ' pathology' and it opens up in a window.

It's a sad fact of life that it's often not the knowledgeable people that get to make the widely publicised statements and influence decision makers. The GP in question obviously isn't aware of the Pathology Overview report, which does seem to call results something other than just "pathology"

Reports - grouped by Test Name and ordered by Specimen collection date
01-Dec-2023 to 27-Mar-2024 (7 months ago)

Organisation	Specimen collected date	Time	Test name	Status	Report	Report group
Launceston Pathology	27-Mar-2024 (7 months ago)	15:48	ED-.FBE	Final	1st Report	(View 2 more within 2 months)
		15:48	SE-_ROUTINE CHEMISTRY	Final	1st Report	(View 1 more within 2 months)
		15:48	SE-FERRITIN	Final	Report	
Launceston Pathology	03-Feb-2024 (9 months ago)	00:00	FOB-OCCULT BLD 1	Final	Report	
		00:00	FOB-OCCULT BLD 2	Final	Report	
		00:00	FOB-OCCULT BLD 3	Final	Report	
Launceston Pathology	23-Jan-2024 (9 months ago)	14:36	SE-_B12, FOL & RC FOLATE	Final	Report	
		14:36	SE-ACTIVE B12	Final	Report	

The Doctor in question should be aware of it now though as I managed to ~~hunt her down~~ ascertain her practicing location by utilising publicly available resources and email her this information.

Could the MyHR be improved? For sure. But let's not conflate system deficiency with a lack of user knowledge or an anti-everything government attitude. Let's also remember that what is perceived as a MyHR issue can sometimes be a bug in the connecting clinical software.

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To be fair Mr Butler's speech did go on to rightly celebrate some notable achievements from the last few years. There's no doubt that eprescriptions and associated online viewability of medications have been for the most part a huge success. There are also many more hospitals and Investigation providers uploading to MyHR. The minister flagged his intention to introduce legislation to make the uploading of investigation results compulsory for laboratory's.

Related to this was the restating of the intention to make pathology results available to the patient immediately via MyHR. I know a lot of clinicians are wary about this and personally I share their concern and feel the status-quo is about right. However there are consumer advocate groups that lobby for the opposite and they are being heard. They point out that this is the case in other countries. This may or may not be true, however I'm increasingly convinced that maybe other countries should be learning from us as opposed to the other way round.

At the bottom of the last page I mentioned that your clinical software may sometimes be responsible for things that MyHR get's blamed for, which brings me to….

Medical Director breached their self-imposed communication with customers embargo last week by announcing a 5% price increase in their clinical software product. A couple of things about their email tickled me…

there are a range of factors taken into account when reviewing our prices, which include:

The current economic conditions

The Consumer Price Index (CPI)

Higher operating costs

Is it just me or is that just three ways of saying exactly the same thing? And if you want to be technical and say that they are all *slightly* different, then I would ask what the CPI has got to do with this *at all*. Is the software now more expensive because the programmers have to pay more for their lunch? I'm a little surprised they didn't throw in climate change and the war in the Ukraine for good measure.

Then there is:

> ***Fortnightly improvements to Helix by Telstra Health:*** *We release features, enhancements and bug fixes every fortnight.*

Okaaay, not sure I'd be boasting about releasing bug fixes every fortnight! Also, there were problems with MD's 4.3 update and there has been talk about a patched version for literally months now.

Best Practice get's to spend some time in the naughty corner this month too. The quality of their software is really good and a major reason why my job is usually enjoyable, but this month they released their *Spectra* update and when it became apparent that it had some massive issues, they withdrew the update after just a few days. I have to say this isn't the first or even second time they have had to do something like that this year. Suffice to say, that if your IT team have downloaded but not installed the original update, **tell them not to**.

That's more than enough haymakers for this issue, happily I can sign off with some positives. Firstly the National Cancer Screening Registry (NCSR) issued a really good resource this month in the form of a guide to using their hub via your clinical software. Whilst it talks about installation it also has good information on usage, so even if you have been connected for a while, you should grab the pdf from this page. It even has information for Communicare users, both of them!

AI scribing is of course a big topic at the moment. I would certainly like to see a bit more structure around it's use, which is why I was impressed by this article. It's a bit of a guide to implementation and evaluation, and whilst it's done by the people at Heidi, it absolutely would be relevant for any AI scribing product you are thinking about. It's a feature of our times really, that many of us are using technology that we don't fully understand. Which is fine when everything is working well, but that won't always be the case. I'd also love someone to trial the main offerings and comment on their relative quality with regards to the basic functions of things like accuracy and reliability, (as opposed to whether it understands Klingon or elvish)

There was a new Healthlink Smartforms option for the THS added in the last month or so around *funding for surgeries not routinely performed*. I have no idea what that actually means, but happily you can read all about it here.

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Dr. Fady Zaky is a highly experienced General, Interventional, and Structural Cardiologist, practicing at Launceston General Hospital and St Vincent's Private Hospital, Launceston. He also holds an appointment at the Royal Hobart Hospital, where he performs complex structural cardiology procedures. Dr. Zaky's practice is focused on providing patient-centered care through advanced interventional techniques to treat both coronary and structural heart diseases.

Dr. Zaky graduated from the University of Sydney and completed his specialty training at Concord and Wollongong Hospitals followed by a fellowship in interventional cardiology at Townsville University Hospital, then a two-year fellowship in structural heart intervention at St Paul's Hospital, Vancouver, under the mentorship of Prof. John Webb, a world leading pioneer in the trans-catheter valve intervention.

With extensive experience in performing percutaneous coronary interventions (PCI), Dr. Zaky excels in complex coronary procedures. He utilises the latest evidence-based techniques to achieve optimal outcomes for his patients. In addition, Dr. Zaky is highly skilled in structural cardiology intervention, providing advanced minimally invasive treatments for valvular heart disease including trans-catheter aortic valve implantation (TAVI), mitral and tricuspid valve repair, and the closure of congenital heart defects like atrial septal defect (ASD) and patent foramen ovale (PFO).

In addition to his clinical work, Dr. Zaky is a dedicated educator, presenting at national and international conferences and regularly mentoring trainees. His research has been widely published in peer-reviewed journals, particularly in the fields of coronary artery disease and structural heart interventions. Committed to compassionate, evidence-based care, Dr. Zaky focuses on both preventive cardiology and the treatment of advanced cardiac conditions through interventional techniques, continually striving to improve cardiovascular outcomes for his patients.

Dr Zaky can be referred to at the Launceston Health Hub, 6388 8115 Healthlink EDI: *lmc32lmc*

e-referral

The THS ereferral system continues to evolve and improve, with the last month seeing some minor reorganising of some of the service groupings. These include the creation of a *Gastroenterology Services* section as well as a *Respiratory and Sleep Medicine Services* area. There are also some other service group consolidations, which is just as well as the list is getting pretty long and we know that having to scroll too far can be a pretty triggering event for some GPs. Although to be fair there may now be an extra click sometimes, so it's a case of moving the pain from the *too much scrolling* group to the *too many clicks* group. I feel this is an ideal opportunity for a Venn diagram, but alas, I'm running out of space ☺.

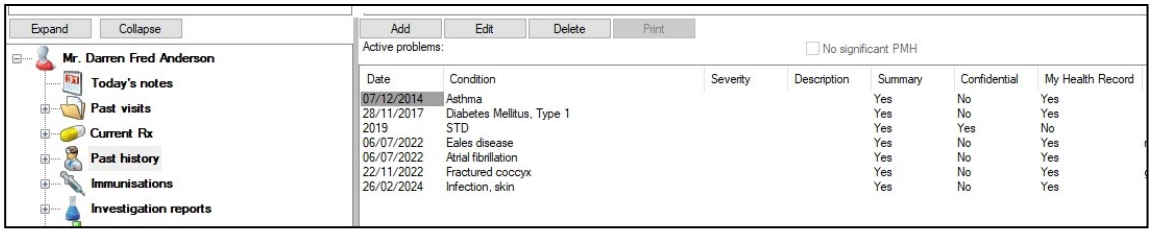
On a more serious note you can read the details around these changes in the left hand column on this page. This is actually a good status page for the THS ereferrals program and I should also mention that at the top of the right hand column under the **Providing Additional Information** heading there is information around updating referrals *at different stages of the process*. This is worth a read as there is sometimes confusion around this.

BP

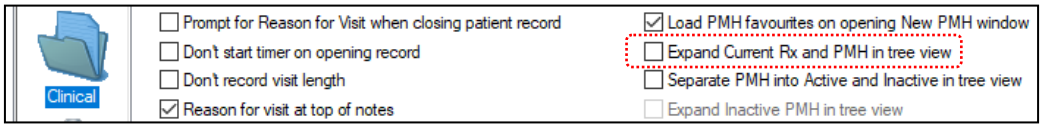
I thought it might be a good idea to revisit some Best Practice hot tips. Newbie Drs get shown these as part of their training with me, but there is potentially a bunch of relatively experienced users that are unaware of some of this. So without further ado…..

Best Practice Tips - Part 1

1) Collapse the menu:

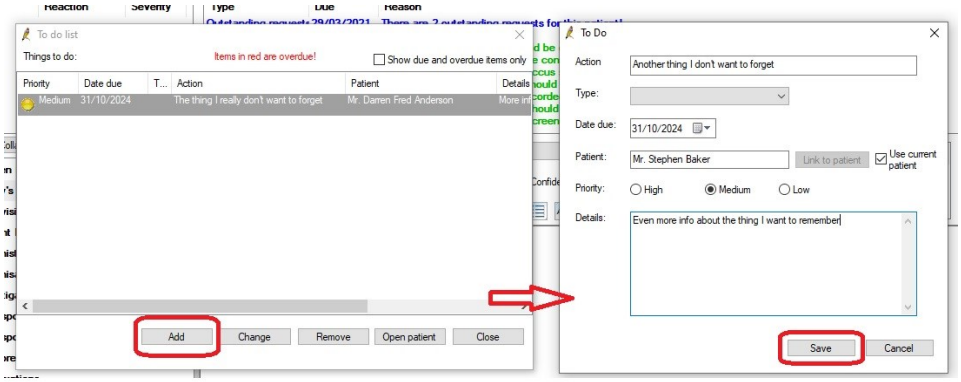


Best Practice by default expands the tree view on the left hand side of the screen to show current medications and Active History Items. In a complex patient this means all the other parts of the screen have to be way off the bottom of the screen, thus much scrolling. I much prefer to have the tree as a condensed menu and do my reading on the right hand side where the information is presented in a much more legible way on a bigger part of the screen. I rarely expand the tree on the left, just single click on the heading. This method is preferred by 90% of new Drs that I train as it presents a less "busy" view of the patient information. You can just click the *Collapse* button, but may will want to uncheck the box in the GP preferences.



2) To Do List:

F6 key on your keyboard in any screen in BP brings up your To Do List. It really is the electronic equivalent of the sticky note you scribble and throw away when you finish.



It's great because:

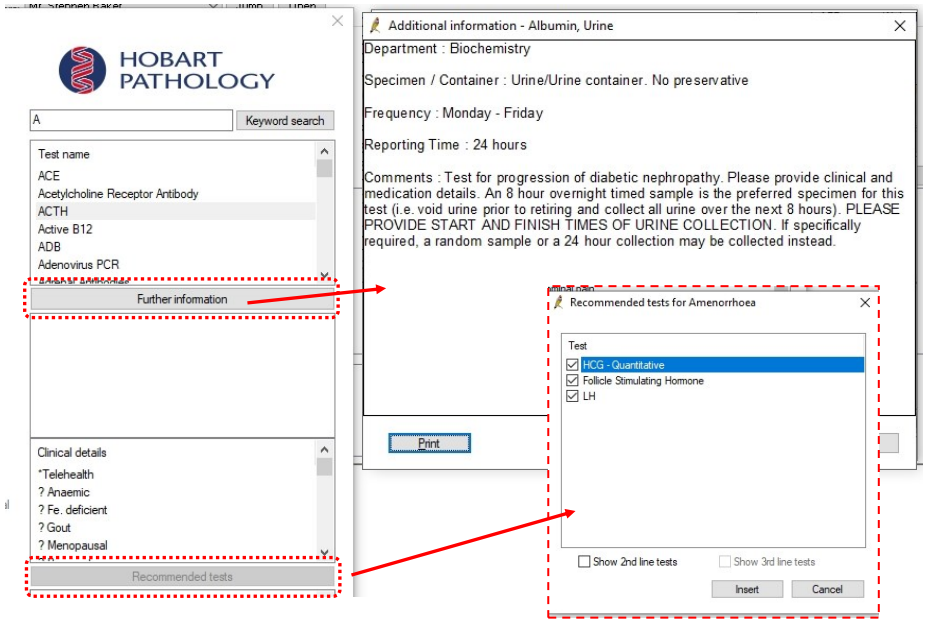
- It's **never part of the patient record** (linking it just allows you to open the patient)
- No-one else can see it, it only lives under your login
- It's F6 from any screen in BP
- Simply delete the item when you have completed it
- Doesn't have to be related to a patient
- You can even send an F8 message to this list (or enable it to pop up when you log in)

It's got priority fields and also a drop-down for the type of action, but who cares? You just want a one button list that you can quickly add to and delete stuff when completed. Bazzinger right!

Best Pactice Tips - Part 1 continued…

3) Pathology assistance.

So if you are set up for e-ordering, there is some help to be had from the request screen that you may not be aware of.



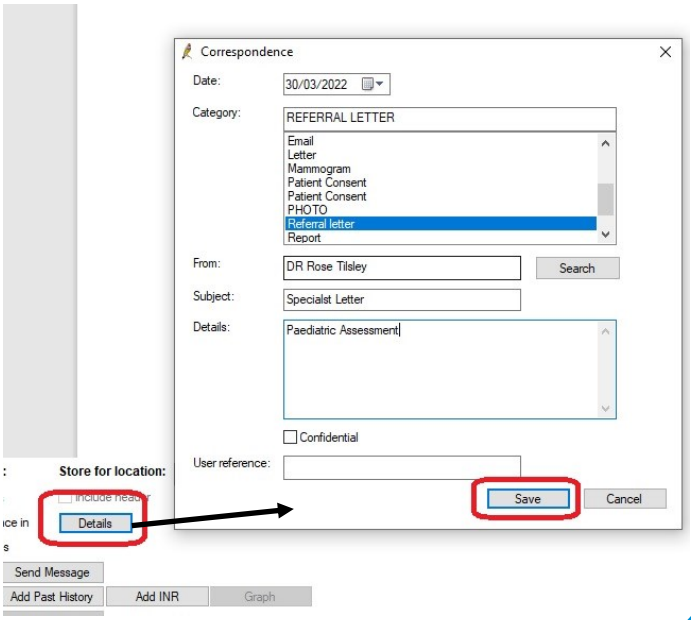
So the graphic hopefully conveys 2 things. Select a pathology test and the *Further Information* button gives you good information about the collection process. I've discovered that the TML version (depicted) actually gives you a little more detail and is better laid out than the Sonic Labs (Hobart/Lton/NW pathology) option. But they are both helpful. Select a suspected illness from the clinical details area and click the Recommended tests button, to give you just that. A selectable list that can be quickly added to your request form.

4) Rename Documents from the InBox

It's a fact of life that incoming letters aren't always helpfully labelled.

Don't neglect the *Details* button in your InBox which let's you change the document Subject as well as add useful Details in the area provided.

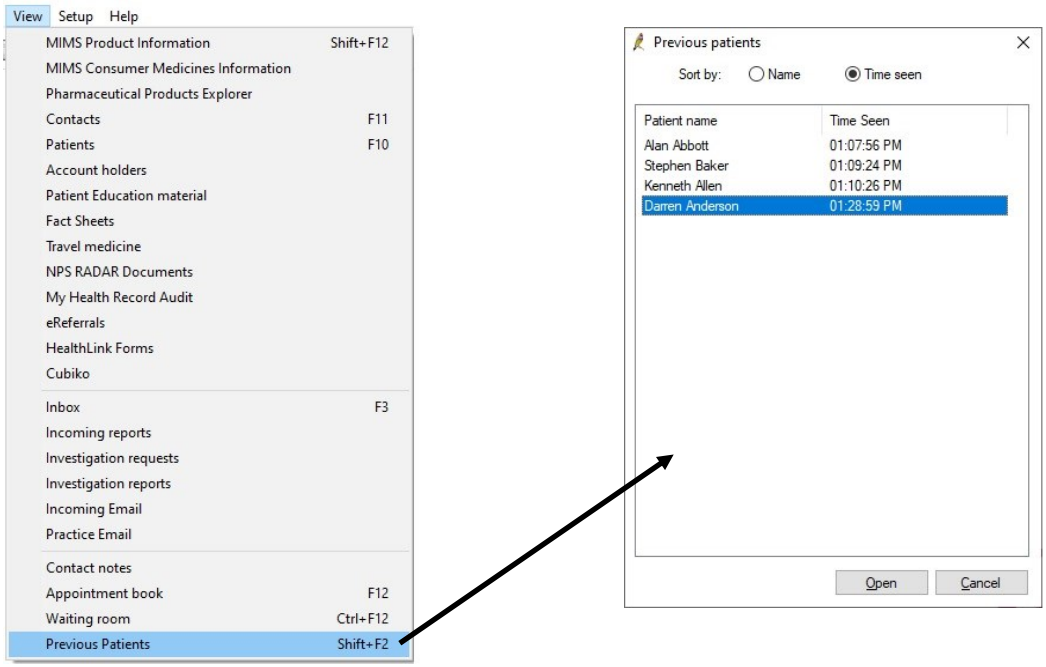
This investment in documentation will make for far easier identification of documents in the patient record. The *Details* button is also available in Correspondence In in the patient record. Sadly we don't get this function for pathology results, although it's probably less necessary.



Best Pactice Tips - Part 1 continued…

5) Previous Patients

This is by far the cleanest way to re-open a record for someone who attended earlier today.

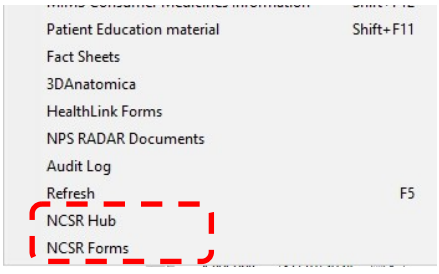


Do this from the main screen in BP. Don't mess around with appointment status in the appointment book, just do this!! The record opens seamlessly for you to resume what you were doing, nothing else is affected. It will remember everyone whose record you opened since the start of the day even if you have logged off at some stage. Just use this!

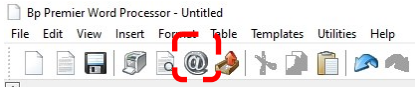
6) Missing Potential addons

If you are not seeing this in the patient record.

Or this in the patient record under the *View* menu.



Or this in the Word Processor.



Then I would ask why these haven't been set up. **Part 2 next week**.