PracSavvy

Clinical Systems Support and Training

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August 2019 — Newsbrief

Welcome to the August newsletter. This month heralds the start of the new QPiP incentive, which will hardly be news to practices, but there is more information to be found here.

PenCat

One of the immediate consequences of the new incentive is that practices have been visited by technical staff and have had new installations of the PenCat program, along with a data collection scheduler and the TopBar program, as part of a Cat Plus suite.

I haven't seen the specifics, but it appears that in some practices the scheduler has been configured to do a monthly extract in the middle of the night, with the result being a normal data extract and a de-identified extract derived from this to be sent to Primary Health Tasmania. An upside of this is that practices will always have a reasonably recent extract available for their own purposes, without having to take the time to do a collection.

It's worth remembering that in it's various incarnations, Primary Health/Medicare Local/GP South has provided the PenCat tool free to General Practice since 2008. Whilst there was always an intention to ask practices to submit data, PenCat has functioned as an invaluable management and audit tool in the interim, and should continue to be used as such going forward.

I'm sure (well fairly sure) that Primary Health will provide *meaningful* feedback to practices on the data benchmarks, but there is nothing wrong with practices keeping an eye on this information independently. Pen systems always provide good information and support resources and they have created a series of "recipes" for each of the benchmarks. The recipes are available at:

https://help.pencs.com.au/display/CR/PIP+QI+Improvement+Measures

The benchmarks mentioned above comprise the eligible data set that has to be submitted to Primary Health, but there are no targets for these measures, so practices if they want to can decide on their own measures to focus on in order to meet the second part of compliance, namely participation in *continuous quality improvement* activities.

eReferral

Please note the following ereferral changes:

- Dr Frank Kimble Plastic and Reconstructive Delete *fwkimble*

As always my full list can be found here.

Templates

The following new templates were created or updated during the last month and are available here:

- General Practitioner Assessment of Cognition (GPCOG)
- National Adverse Event following Immunisation (NAEFI) form
- Social Worker Referral- Huon Valley Health Centre (updated)

Note: I'm told that the current RHH Clinics referral template (May 2019) is showing an older fax number for the Haematology clinic. The correct fax no is **6173 0484.**

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MD

One of the indicators available in the PenCat Data Quality dashboard is the one depicted below.

Medical History		85.48 %	View 4th Edition Fact Sheet

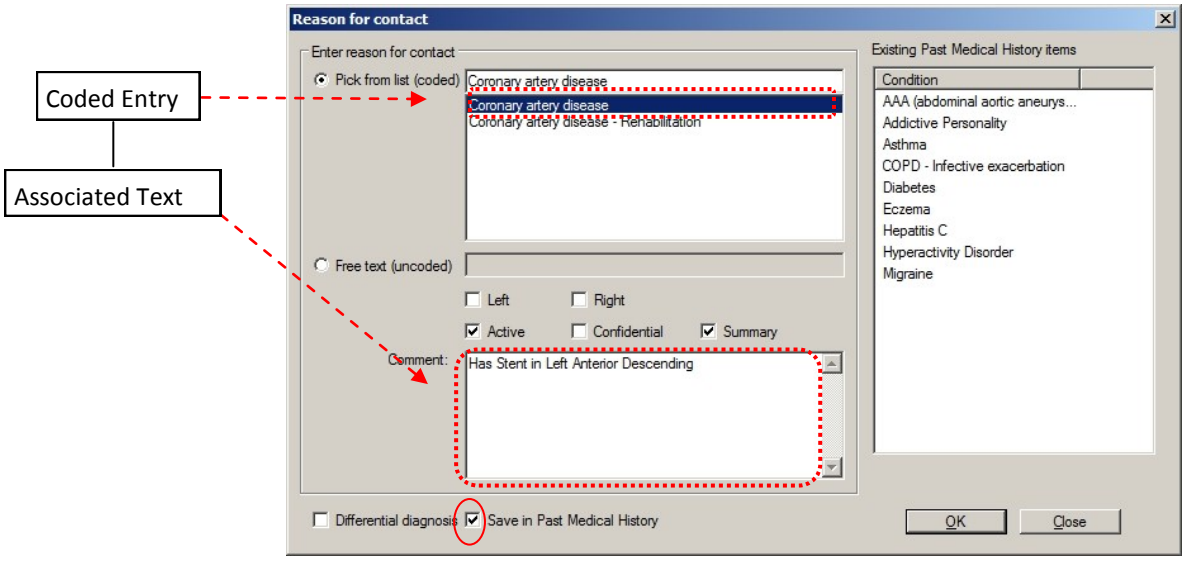
The indicator above, tells us that of all the Past History entries in the patient database, 85.48% of them are *medically coded*. Coded entries enable MD's built in contra-indication checks to work and enable both the program and it's users to identify patients with a given disease or illness. Coding a diagnosis is as simple as selecting it from the provided drop-down lists in MD.

I was at a practice recently looking at another one of the PenCat reports, namely the *Indicated COPD with no Diagnosis* report. We had a look at the patient's past history and COPD was indeed referenced, along with some accompanying information. In fact the other items in the history also had useful contextual information right alongside the diagnosis. The history had obviously been maintained with care and attention to detail, but this had been accomplished by free-texting 8 out of the 10 items in the history.

Free-texted history items are not coded and will not be included in system drug-disease interaction checks.

Patients who have free texted disease entries will also not appear on disease based database searches, thereby compromising the practice ability to potentially *identify and intervene*.

MD however can certainly cater for the understandable desire to include more information alongside a coded diagnosis. Once you have decided that the condition warrants being included in the past history, ticking the *Save in Past History* box will make the comments field available, where you can then enter more information, as per the graphic below.



Information recorded in this way will transfer through to any referral letter as long as your template is set up appropriately. It will also show on any Shared Health summaries uploaded to the My Health Record. The comment will also show on the Past History screen in MD, although due to a screen layout that largely ignores the advent of wide screen monitors, the information will show at bottom left when the disease is highlighted, rather than in the acres of empty screen space to the right of the history list.

With regard to the real-life example we started with, when I (along with practice staff) changed the entry to a coded one, the system immediately generated a warning for one of the patient (*continues*)

Continued..

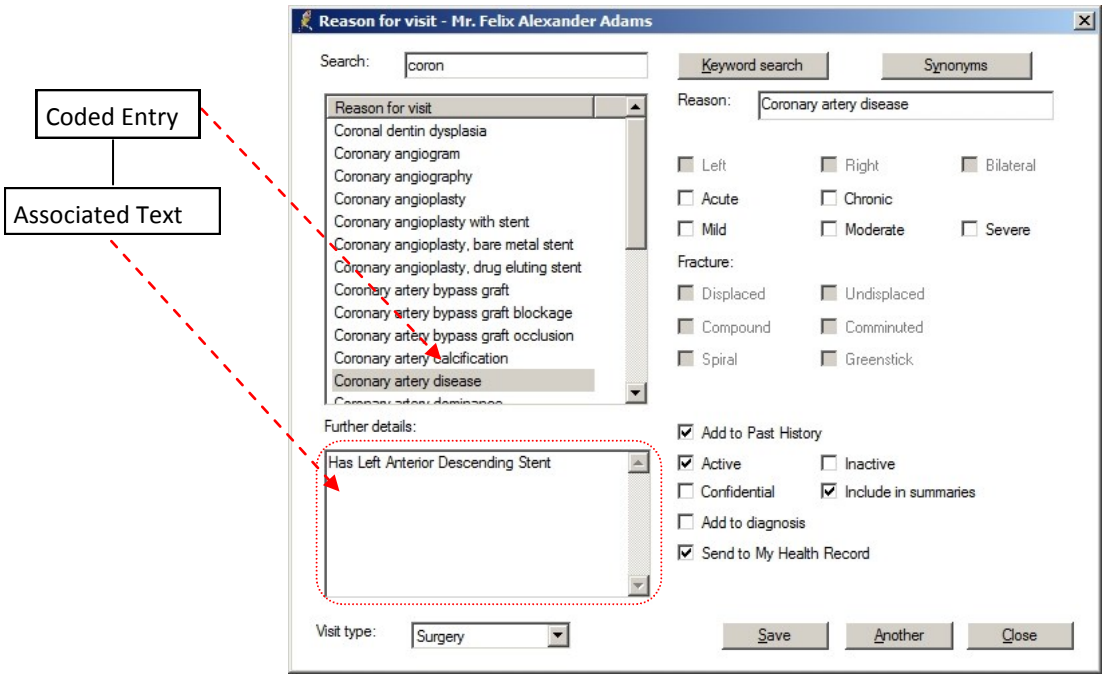
medications and it's possible side- effects for COPD sufferers. There is every chance that the GP was fully aware of the issue, but it remains a perfect example of how the system can assist you if you use it well.

So don't let the need for adding extra information hobble the efficiency of your patient's electronic medical record in both your own system and any future practice system it may be exported to.

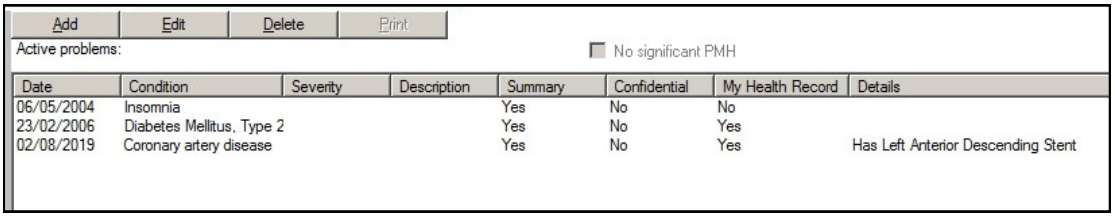
BP

I'm pretty sure MD users read the MD articles and BP users only read the BP articles, so for the preamble to this information BP users may want to glance at the first 4 paragraphs or so on the previous page.

The main aim of this article is to illustrate that you can add information to a diagnosis whilst still using a coded entry and therefore not compromising medication/disease system interaction checking and searching. As soon as you decide that a *reason for visit* or *reason for prescription* warrants being included in the *past history*, ticking that checkbox enables the comments section as shown below.



Extra information entered this way will appear alongside the diagnosis in the history as depicted below. This information will also appear on any of your template driven referral letters or care plans, as well as showing when you upload a Shared Health Summary to the *My Health Record*.



Date	Condition	Severity	Description	Summary	Confidential	My Health Record	Details
06/05/2004	Insomnia			Yes	No	No	
23/02/2006	Diabetes Mellitus, Type 2			Yes	No	Yes	
02/08/2019	Coronary artery disease			Yes	No	Yes	Has Left Anterior Descending Stent

It's important to remember that un-coded history entries may not just be as a result of input by your clinicians. Sometimes when medical records are imported from other practice systems using different clinical software, the information comes in as a textual rather coded format. A tell-tale sign of this is when entries in the history are shown in BLOCK CAPITALS. Replacing these entries with a coded entry is a good thing to do.

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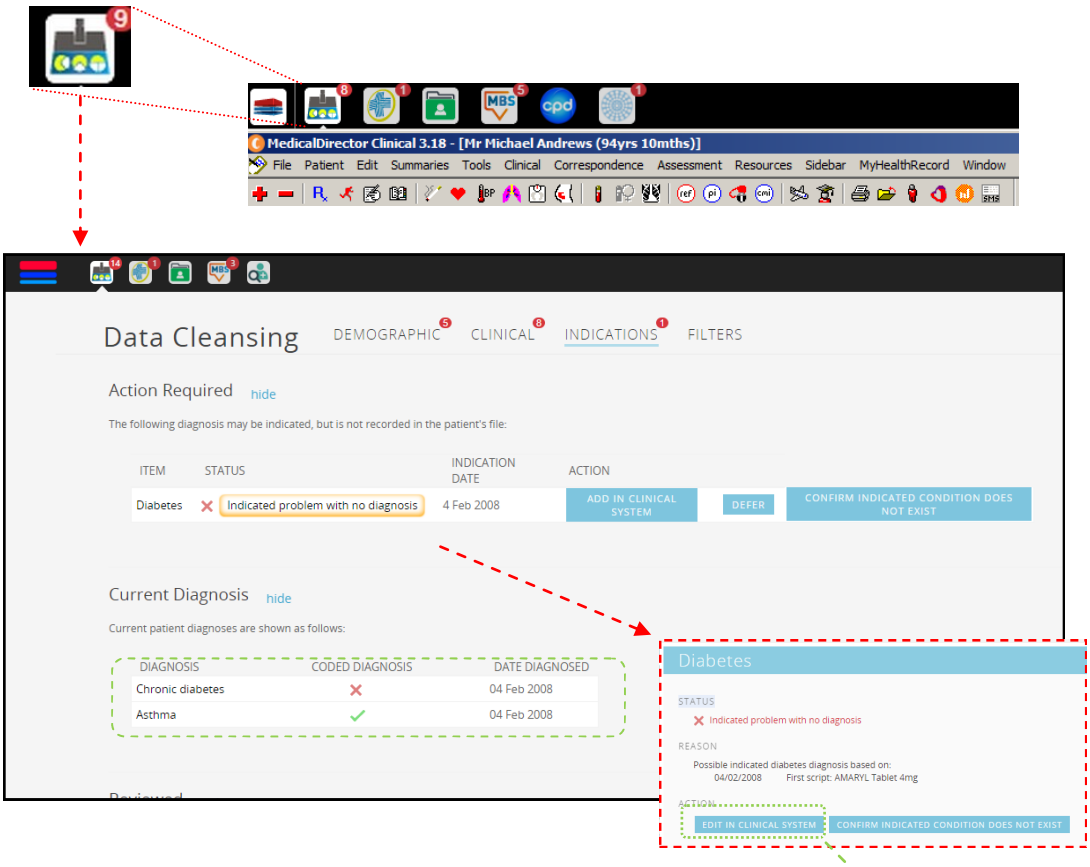
TopBar

Continuing the theme of diagnosis being un-coded and therefore not recognised at system level, in the April newsletter I talked about the fact that the TopBar program can alert us to this at point of consultation via the *Data Cleansing App* and It's *Indications* section.

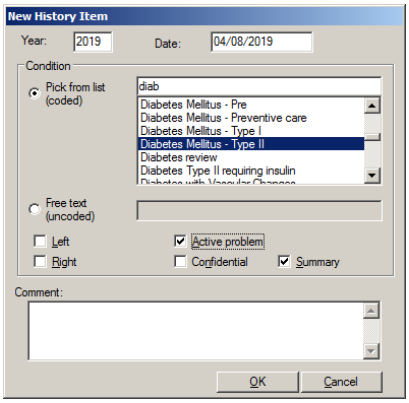
The *possibly indicated* diagnosis may be either; missing, uncoded and therefore not recognised, or actually not applicable, remembering that TopBar gives us traffic-light type cues to show how strongly it feels about the possibility of missing diagnosis. The example below gives us a definite maybe for a Diabetes issue.



As mentioned, in the earlier newsletter, clicking on the potentially indicated diagnosis reveals the rationale TopBar has used in arriving at this conclusion.

As extra assistance, we can also see a list of current diagnoses, and whether they have been coded or un-coded. The example above, clearly shows that whilst Diabetes is present in the history, it is un-coded.

Seeing this, we can click on the *Edit in Clinical System* button that will take us straight to the patient history where the necessary amendment can be made.



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