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Clinical Systems Support and Training

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January 2021 — Newsbrief

Welcome to my first newsletter of 2021. No rants or sermons this issue, just hope that everyone had a good Christmas and that 2021 is at the very least more predictable than 2020. Predictable would be nice!

It's also of course the time for resolutions, and no this is not my cue to bore you with nags about system security or data quality, rather taking the opportunity to let you know my resolution, which is to learn to speak Mandarin,……no reason! 🥴 I'm also not going to be one of those people that claim nothing good came out of 2020. If I did that I'm sure you would all remind me of the new Springsteen album and the admittedly happy fact that an internet troll is no longer in charge of the world's largest free democracy.

Actually, I generally try and stay away from politics in this newsletter at least. People do seem to have polarised views on things, rarely meeting on sensible middle-ground. For example some may consider the following 'key findings' document, a jaw-dropping *light bulb* publication, whilst others may think 'Well Duh' I'm not going to say where I sit, other than to say, my favourite bit was "*Tasmanians who see their GP multiple times in one year are more likely to have health problems*,..."

I was extremely fortunate in 2020 in that neither myself or my business personally were impacted much by Covid. It seemed to give me a bit of a licence to inject a bit of humour into the newsletter, and happily the crisis did speed up the acceptance of new technology into the health sector, so there was plenty of sensible material for me to work with too. Consider what's come about:

- Scripts can now be sent via sms or email
- Some imaging requests can be sent electronically
- Recalls and Reminders are increasingly sent via SMS
- Some THS clinics can be electronically referred to*
- Referrals/Requests sent electronically from GPs in Nov 2020 triple Nov 2019**
- THS doctors can now view the MyHR.

* Albeit with a dodgy template
** MDExchange figures not available

The changes continue on February 1st when compulsory *Active Ingredient Prescribing* becomes law. This change will be apparent when relevant software versions are installed, namely MD 4.0 and BP Saffron. Check the next page for a bit of a summary of the whole thing.

eScripts will also be available to ALL practices this month, with MD including it in version 4.0, (practices may already have the functionality if they have 3.18c installed) and BP switching it on with their January Drug update for those that aren't already running it but are running Jade SP3 or SP4.

Just when you thought that was enough change, on Dec 15th my favourite software for practice training has 'had work done'. Yes, PenCat has had a cosmetic makeover and whilst these things can turn out badly, they can also turn out great, and I'm really enjoying the new look. See page 3 for a bit of what I like.

Lastly, for my customers, I won't be available for onsite visits between 28/12 and 8/1 as I indulge in a little road trip around the state. I guess if your practice is in/on Bruny, Bicheno, Cradle Mountain or Stanley, and you have a problem, I could make an exception. I will still be answering emails and taking phone calls, providing there is coverage.

Templates

The following new or updated templates are available at my website here:

Advance Care Directive Tasmania (2020)

eReferral

Please note the following Healthink EDI changes, main listing here:

Dr Jan Batt	Obstetrics and Gynaecology	*hobartog*	Delete
Dr Jan Batt	Obstetrics and Gynaecology	*ewhealth*	
Dr Kate Mitchell	Obstetrics and Gynaecology	*ewhealth*	
Mr Simon Thomson	Plastic and Reconstructive	*sjthomso*	Delete

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Active Ingredient Prescribing (AIP)

As mentioned on the first page and in a previous edition, from 1st February 2021, scripts for **most** PBS/RPBS medications will list the Active Ingredient rather than the brand name. When a GP has specified a certain brand, this will appear in brackets **after** the Active Ingredient name.

The rationale for this change in scripting can be summed up as:

- Increased patient awareness of what drugs they are taking
- Resultant decrease in medication duplication
- Reduction in PBS bill leaving scope for more drugs to be added
- Generic availability will help offset brand shortages
- Potential reduction in medication related hospital admissions*

** Current cost 1.4 billion per year plus estimated 400,000 ED attendances*.

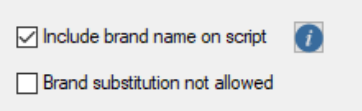
There are exceptions to AIP, namely:

- Custom preparations
- OTC medications
- Paper based medication charts in ACF's
- *List of Excluded Medicinal Items* **(LEMI)** e.g. Vaccines, dressings vitamins.
- Prescriptions for medications with 4 or more active ingredients

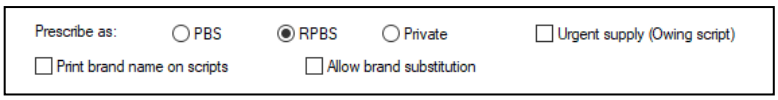
There is very little change to GP prescribing behaviour, it's much more about what appears on the script. To reiterate, with the above exceptions it will be either Active Ingredient(s) or Active Ingredient(s) followed by the brand name in brackets.

The GP can still select the medication by brand, but if the GP wants the brand and a non substitution setting on the script, he/she will have to mark the requisite boxes on every new script. There is no default or preferences setting that can be checked.

In MD via the Dosage window



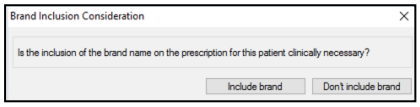
In BP via the Quantity/Repeats screen



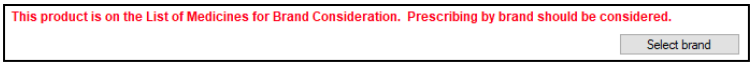
Note: My understanding is that re-prescribing existing pre AIP medications for the patient will retain the previous brand stipulations. (Active Ingredient(s) will still show first on the script)

There is another category of medication that has been recognised as a sort where brand adherence **may** be desirable, although the final choice is with the prescriber. These medications are referenced on a list called *List of Medicines for Brand Consideration* **(LBMC)**, and this will be updated via the monthly drug updates. If the medication being prescribed is on this list, you will be asked if you want to specify a brand, and if you do will be presented with a list of brands.

In MD



In BP



Note that this is only for guidance, the prescriber makes the final decision, and as mentioned above, the *Active Ingredient* will be listed first on the script, (unless a LEMI item).

The real key to this is patient education, with a good patient handout available here and a nice generic 2 page guide for prescribers from the NPS available here. Other than that…

MD: Online Help Webinar Discussion **BP** Videos (Patient/GP) Online Help FAQ

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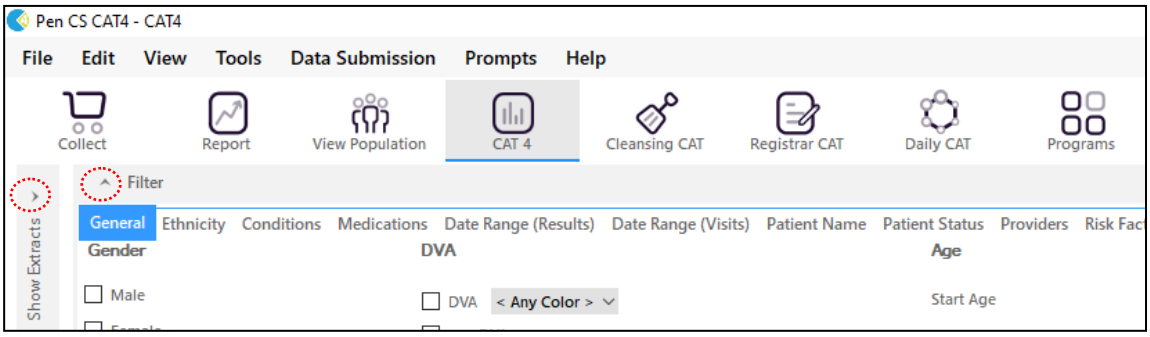
PenCat

Pen has just updated it's Cat4 tool, mainly in the area of appearance rather than adding any more analytic power, but I think the changes are going to be well received.

The update was scheduled to be released on December 15th, although at least for me it wasn't available until the 16th. Like those sad misguided people that sleep out overnight so they can be first in line for the latest iphone release, my fingers were quivering over the keyboard in anticipation.

It wasn't a great start, I expected it to be offered as an update in the usual fashion as a result of double-clicking the Cat4 icon. What happened was that my icon gave an error message when I double-clicked it on 2 different computers. So I ended up running the Cat4 installation link. It took quite a while, and when I signed in that took quite a while too. Looks like that was initial teething problems though, with things working well since.

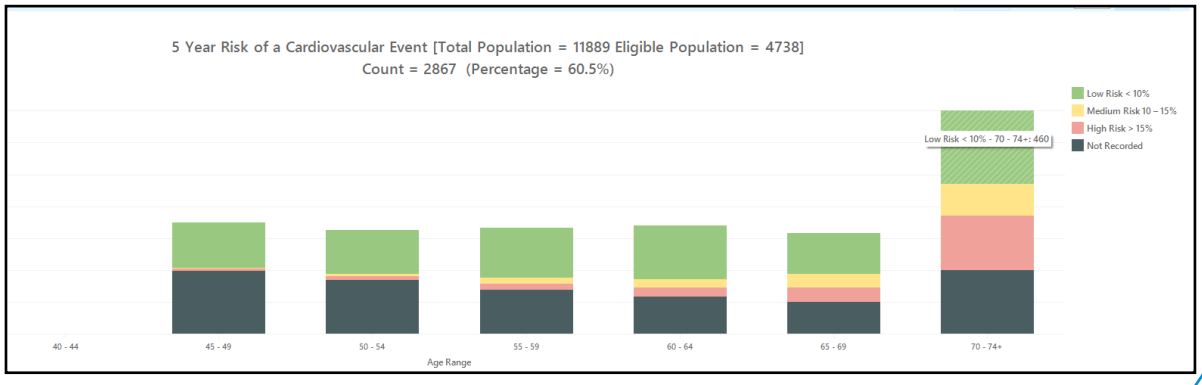
When I loaded the sample dataset though, the good stuff started to become apparent. The first thing I noticed was that it took me straight to CAT 4, without pausing at the *Dashboard.* Secondly a couple of buttons were missing from the top.



The *Show Extracts* and *View Filters* icons have been banished. These sections are now accessed by clicking on the little arrows marked near the corner of the graphic.

When you have an extract loaded, the changes are noticeable. Looks aren't everything (happily), but they aren't nothing either. The graphics have *transitions*, along the lines that people use in power point presentations. So the first time you go into one of the graph screens it transitions or grows into your screen, rather than being present as a static graphic. If you select a portion of a graph, it detaches from the main graph so it is more obvious what you have selected. If you change the filters, e.g Filter for *Active* patients, you see the graph screen that you have active, grow or shrink before your eyes. I spent ~~quite a while~~ hardly any time at all changing the filters so I could watch the graph transitions.

Another thing that has changed is the introduction of a standard traffic light colour scheme through all the graphs, and it works well, particularly with the stacked-bar type graphs. They have also standardised the convention of black as the colour for *Not Recorded* segments.



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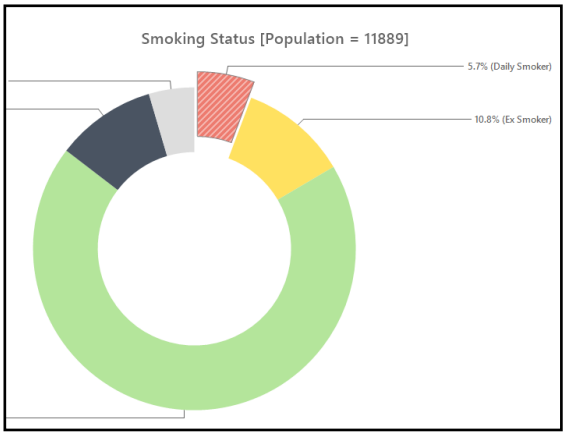
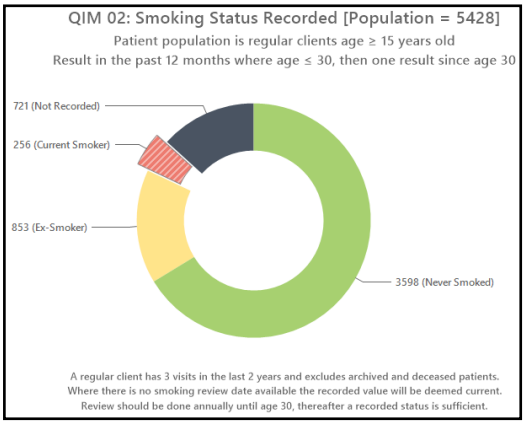
You may also notice from the previous illustration that if you hover the mouse over a graph segment it displays the legend and the number of people represented by that segment. Double clicking on a graph segment seems to display the patient list a little quicker, and you have a much bigger choice of file formats that you can export the data to. Having said that, in terms of analysis the ability to export to Excel has always been available as a choice and is probably still the best option.

I haven't fully tested this, but I have a feeling the printouts of patient names may be a little more paper economical, Cat4 has never been efficient at printing. Hint - if you want to optimise paper use in printing, export to Excel and use the page and scale tweaks there to save paper.

Another big change is that pretty much all of the Pie graphs have been replaced by doughnut graphs.





I think they work pretty well too. Note the traffic light stuff and also the detached segment making it clear what's been selected. It does look good but I do wonder if the move from pies to doughnuts is symbolic of Australia's culture becoming less English influenced and more American influenced. For example, Black Friday…..WTF is that to Australians??

As a side note, people often struggle to find the QPIP graphs. In this release you can find them as a sub-tab under the *Standard Reports* section, and also under the *Programs* icon at the top of the screen.

Whilst it's mostly cosmetic there are a couple of minor functionality updates, namely:

- Additional Lipid Modifying drugs now mapped
- Additional diabetes drugs now mapped
- GoShare Functionality changed
- Removal of Pap Smear report and inclusion of sections for Opted Out/No Longer required in CST reports.
- Minor fixes and enhancements.

Happily PenCS have avoided the trap of change for change sake, (I'm looking at you Microsoft Office) There may be other subtleties that come to light, but that's the gist of it. Cat4 has now become a more polished and modern presentation tool. In the right hands it could make for a really appealing demonstration of your practice data.

So there it is, in summary your tried and trusted search and analysis tool has just got a looks and presentation makeover. Put another way, it's gone from this to this.

And I'm good with that! ☺

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A few weeks back it was apparently Australian Cyber week, and the Digital Health Agency marked the occasion by launching The art of Cyber Self-Defence, a six step guide keeping your practice systems and data safe. Whilst many of you would have read much of this before, experience tells us that there is sometimes a significant time gap between assimilation of information and direct action. With that in mind, time to bang the drum again.

Step 1 - **Improve staff awareness by getting them to do the online course.**

Things often go wrong as a result of a combination of factors, rather than just one thing. Increase the odds in your favour by getting them to do the Digital Health Security Awareness online course. Amongst other things, the course reinforces the safe online practices that we should all be aware of as well as steps to be taken in the event of a data breach. If nothing else, I would encourage at least pm's to do the course.

Step 2 - **Keep your software up-to-date.**

Software companies like Microsoft don't continually release patches and updates for their own amusement, they do it to fix discovered vulnerabilities in their own software and to try and stay one step ahead of hackers and more malicious operators. So make sure that these patches get done and these updates get installed. One of the biggest ransomware attacks in history happened in 2017 and was known as the Wannacry attack. It effected almost 700 health related organisations in the USA, targeting a vulnerability that **Microsoft had released a patch for 2 months previously**. So talk to your IT support and make sure that someone is on this issue, and has a system in place for applying these updates, to your server in particular as well as the other practice devices.

The same thing goes for ensuring that your anti-virus software definitions are being automatically updated. Some times these definitions are your only defence against a virus that has been released within the last few days. Consider either the practice manager or an admin person liaising with your IT support and being shown how to check these things. Your IT guys may tell you that they have issues covered, which is great. Just make sure you ask the question,...**and the second question and the third if necessary**.

Step 3 - Use Strong Passwords

Strong is great, but unique even would be a very good start. If you implement strong passwords in your personal affairs, but are happy with "medical" when it comes to accessing the private medical details of thousands of patients, then what sort of a business are you running? Admittedly both BP and MD don't provide a sensible way for users to change their passwords by themselves, but in the upcoming Saffron release BP is certainly beefing up password strength.

Step 4 - Back up your data

I'm sure that you all do data backups. But ideally your regimen should include the following.

1) Someone is checking the log files daily for a backup failure

2) A copy of the backup is stored offsite (In case the building burns down)

3) A copy of the backup is stored offline (Out of reach of the Internet)

4) Periodically your IT guys are doing a test-restore to ensure things are working properly.

Step 5 - Phishing - Do not respond to unsolicited emails, texts and calls.

Phishing is bogus communication disguised as something familiar, with the intention of extracting passwords or personal information from you. If you think an email or text is dodgy, simply delete it, and never click on a link that doesn't make sense. The course at step 1 will emphasise ways to detect phishing.

Step 6 - If you fall victim to ransomware - avoid paying the ransom

Not my favourite, because if we are taking this step our self-defence has failed and we have fallen victim to a ransomware attack. There is a rationale for not paying, and it is explained here.

Lastly, if you think you don't have the time for any of this, I absolutely guarantee that you won't have the time to fix everything when things go bad!

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