PracSavvy

Clinical Systems Support and Training

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July 2018 — Newsbrief

Welcome to the July newsletter. Can I start by reminding you that July is the final month of another ePiP incentive quarter. Please don't miss out on your incentive target, it really should be "money for jam" now. Hopefully there will be something for everyone in this issue. Best Practice have just released their Indigo update, and whilst sensibly most practices will hold off upgrading for a while, I will have an article on the new features in the August edition.

If you have just started receiving or reading this newsletter and are feeling you may have missed out on previous "gems", all the earlier issues can be found on my website here.

Finally, a big thankyou to the Healthengine people who continue to play their part in making it hard to get people to trust Digital Health initiatives!

Bits

Immunisation:- As you would know, there are changes to the immunisation schedule from July 1st. As at time of writing this publication neither Best Practice or Medical Director have product updates that encapsulate these changes. Both have advised that an ETA for the upgrade is unknown, but you would imagine it wouldn't be too far away.

Instructions for entering non-schedule immunisations in MD can be found here. While not dealing with the non-schedule issue directly, BP does have a useful immunisation guide in pdf format.

MyHR

As you would know the MyHR opt-out period begins on July 16th and runs for 3 months, followed by a 30 day "tidying-Up" period. After that people who haven't opted out and those who haven't already got a MyHR will have one enabled. There will be plenty of media and social media information around this over the coming weeks.

If you have any doubts around the MyHR, there are several ways you can access correct and first hand information. Apart from the source, RACGP and AAPM have resources available as well as the various PHNs. I am also happy to advise or run refresher sessions. The main thing I would advise is for people to get comfortable with the record. It would be incorrect to assume that because you know how to upload a Shared Health Summary, you are fully conversant with the MyHR

On a related note, whilst there is currently no MyHR software template for an Advance Care Directive, there is a MyHR section for this important document. If you want to incorporate this topic into patient conversations there is a reasonable patient-centric guide here that details the steps for uploading this document to the MyHR.

Templates

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

- Dr Mark Wilson (Updated location and contact details)
- Sleep Better Again Referral (South)
- OT Services Community Team Referral (South)

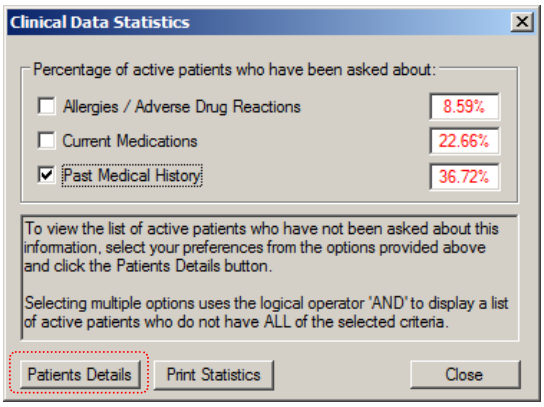
Dr Mark Wilson has new contact details :

Lower Level 2 Calvary Medical Centre
Calvary Hospital
49 Augusta Road Lenah Valley
Ph: 03 6228 0291
Fax: 03 6228 0891

MD

One of the things that can often come up around accreditation time, is the question around how many of your patients have Health Summaries. I always found this hard to quantify, but really what is being asked is the percentage of patients that have information recorded in the Allergies, Current Medications, Past History and Family/Social History areas.

MD gives you some credible help here in 3 of these areas, with a handy tool that is sometimes over-looked (by me at least!) Under the *Clinical* menu at the front screen in MD, click on *Clinical Data Statistics*.

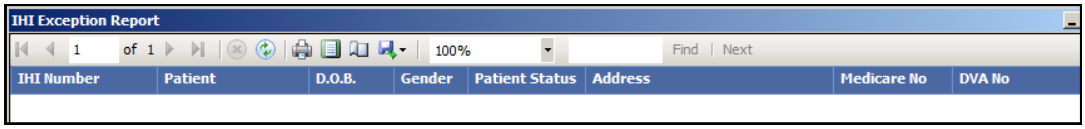


Whilst giving you some quick statistics about patients with information entered in these areas, what's potentially even more useful, is that if you tick one of the criteria, the Patient Details button will generate a list of the patients with no information in that area. In the example above, I have used the utility to generate a list of patients with no Past Medical History. From the list you can open a patient record and either enter a relevant history based on information in the record, or tick the box at the foot of the *Past History* Screen

This would result in the following notation being recorded in the Past History screen. *As of xx/xx/2018 this patient has no significant past history.* Your statistics would be updated accordingly, with the notation being removed should a subsequent history item be entered for the patient. Exactly the same methodology can apply to a patient's *Current Medications* screen, and of course we have always known to mark *Nil Known* in the *Allergies* area if appropriate.

See this month's PenCat article for how to identify patients with no Family History information.

IHI Exception Report Don't be cowed by the tech sounding name of this utility, found under the *Patient* menu on the MD front screen. We know that MD automatically looks up a patient's IHI number when you enter the record, so what this report gives you is a list of patients who share the same IHI number, in short, a quick list of duplicate patients.

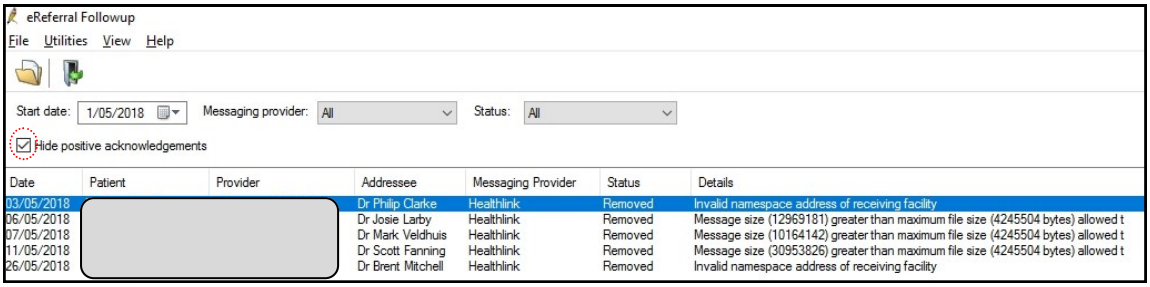


Admittedly you have to have opened a record once for the IHI to be looked up, but this remains a super quick way to check for duplicate patients in your database.

BP

There are a few items available from the main Best Practice screen that can assist practice admin staff in ensuring that things are "ticking over" as they should be, and that no outwards or inwards messages have stalled.

Ereferrals: Since the lava release an *ereferrals* status screen has been available via the *View* menu on the main BP screen.



If you are just checking things, then leave the *Hide positive acknowledgements* box checked. This will isolate problem referrals, with the Details column giving a good indication of the issue.

The most common reasons for errors are:

1) Healthlink EDI typo in the address book (contacts)

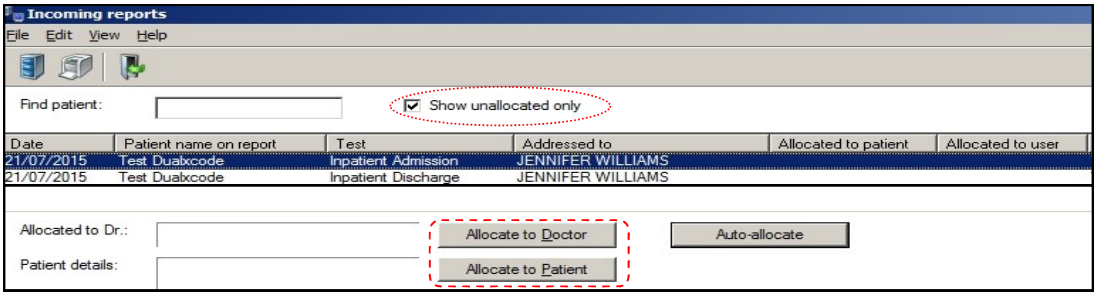
2) GP trying to send ereferral to a provider who has no EDI in the address book.

3) GP trying to send a document that is too big, (often through the inclusion of a large graphic)

Ideally BP would alert the sender of an error when initially sending the document, but unfortunately that doesn't happen, so we rely on this screen to identify any errors. At this point in time, we are using a system that was designed for the transmission and receipt of plain text pathology type messages. For this reason it is best to restrict yourself to text only documents, issues in layout and document size can occur when we include graphics. The near future will include better and more flexible document formats.

If a specialist practice hasn't received a document and you can see no errors, then unchecking the positive acknowledgements checkbox will reveal the messages that have worked fine from your perspective. The *Status* column will show "acknowledged" meaning that the receiving system has sent back a confirmation of receipt. So unless the address book has the EDI of the wrong practice, you should get the specialist rooms to check again.

Unallocated documents: Found under the View menu, Incoming reports lists all messages that have not yet been checked to a patient record.

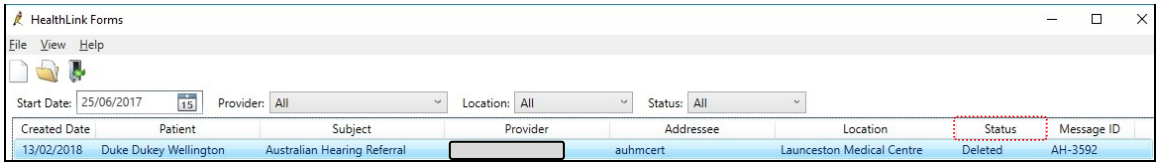


Almost all practices are on top of this bit. Checking the box as shown reveals incoming documents that your system cannot match to a patient and/or GP. Use the buttons provided to ensure the document is addressed to the correct clinician and linked to the appropriate patient so that it travels through your system appropriately and is stored in the correct patient record.

BP

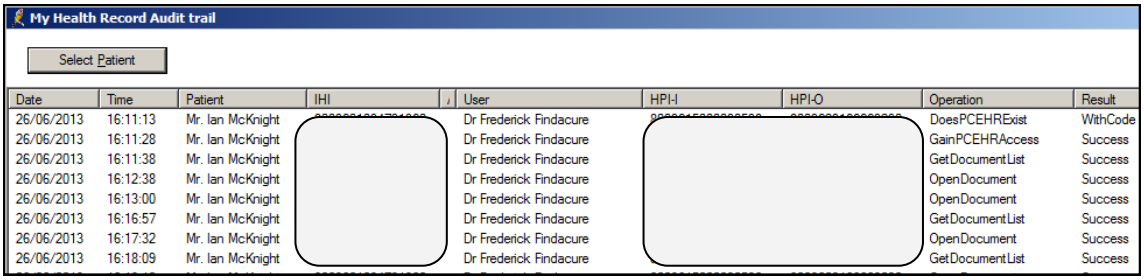
Things to check continued..

Healthlink Smartforms: Found under the View menu again, the Healthlink Forms screen gives you a status display for these documents across the practice.



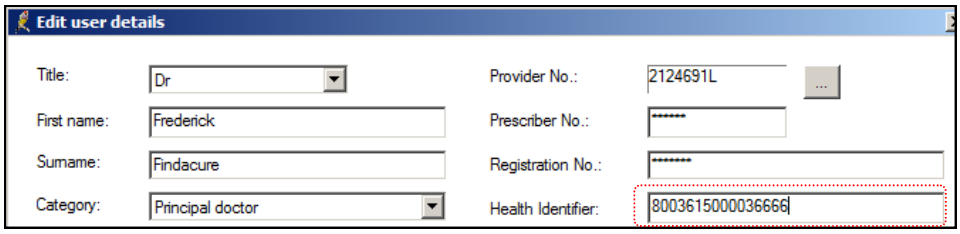
At this stage the only forms available to Tasmanian users are for Australian Hearing referral, but this may well be the method for sending other sorts of referral in the near future. In NSW for instance, Fitness to Drive medicals are done via this method. The key in this view is the *Status* column, where words like "failure" or "rejected" , would denote the need for further investigation. Also, a status of "parked" coupled with a *Created Date* that is a few weeks old, may indicate a referral that was partially completed and then forgotten.

My Health Record Audit: Another monitoring utility under the *View* menu, this is most useful if there is any query about who has accessed a patient's MyHR.



When you first access the utility, a patient selection screen comes up, but if you press *Cancel*, after a couple of moments, the MyHR audit log for the whole practice is shown. One thing that is worth checking occasionally is for the entries with a timestamp of Midnight (00:00) or seconds afterwards. These entries represent an automated Best Practice service that runs every night and checks patients with a downloaded health identifier (IHI) to see if they have an MyHR that the practice can access. For the ones that do have a MyHr that hasn't already been accessed by the practice, the flag is set in the patient record and evidenced by the green shading around the MyHR button. So checking this log occasionally to see that the overnight service is running properly is a good idea.

Still on the MyHR, but a mostly one-off task (unless you have high staff turnover), is to ensure that all your GPs and nurses have their HPI-I identifier entered under their user details, (found under Setup..Users).



Additionally they should have appropriate permissions set for accessing the MyHR. (Not depicted)

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PenCat

Following on from the MD article on Health Summaries, this particular recipe deals with identifying patients who have no Family History entered.

1) Sign into PenCat and click on the Briefcase icon

Then

2) Click on the *View Extracts* icon and select the latest extract, OR click the *Collect icon* if there is not a recent enough dated information extract.

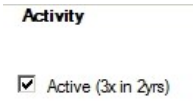
Or

If you select an extract, give it a few seconds to load. If you do a new data collection it will take several minutes depending on the size of your database.

3) Click on the *Hide Extracts* icon as this section is no longer needed. Click the *View Filter* icon.

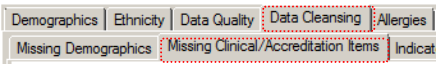
Then

4) On the *General* Filter Tab in the top half of the screen, go to the Activity column and select *Active (3x in 2yrs)* if you want to focus on regular patients.

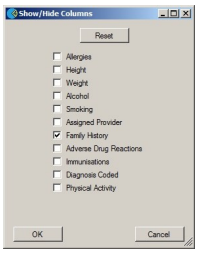


5) Click the *Recalculate* icon. (You must always click recalculate if you make any filter changes in the top half of the screen)

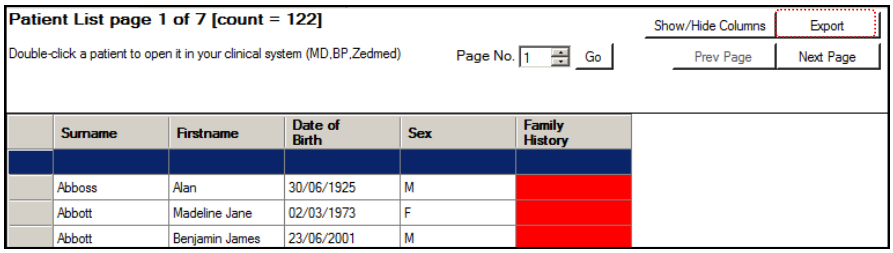
6) On the *Data Cleansing* Tab in the bottom half of the screen, select the *Missing Clinical/Accreditation items* sub-tab.



7) Click the *Show/Hide Columns* button. Untick everything that is selected, and tick *Family History*. Click OK.



The report should look similar to the graphic below.



8) Your report now shows Active patients missing Family History information. Click the Export button to print or save the report. Alternately double-click each of the patients individually to open them in the patient record, and possibly create an *Action* to ask about Family History at the next visit.

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