PracSavvy

Clinical Systems Support and Training

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July 2017 — Newsbrief

MyHR

The end of July marks the deadline for this quarter's ehealth PIP incentive target. If you are registered for this, **please don't miss out and have to pay the money back because you haven't reached this modest and highly attainable target.**

Just to reiterate, the chief measurable goal is to "..have uploaded Shared Health Summaries to the My Health Record (MyHR) system for a minimum of 0.5 per cent of their Standardised Whole Patient Equivalent (SWPE) or the default SWPE, whichever is greater" Remember that the incentive is for the *uploading* of Shared Health Summaries, rather than the registration of patients for a MyHR.

This is the only "measurable" for the incentive, with a couple of the other criteria now being a fully embedded part of your systems. The other things which do require vigilance in order to be fully compliant in order to survive an audit are:

- Maintenance of your clinician's Individual Health Identifier (I-HI) in the clinical software
- A commitment to the electronic coding of clinical diagnoses in your clinical program.

The I-HI part can sometimes be missed when the practice employs a new GP or takes on registrar GPs. Making sure this number is recorded really should be part of the "New Dr checklist". Your coding progress can always be checked via the PenCat tool.

In case a reminder is needed, the monetary incentive is that practices can receive a maximum payment of $12,500 per quarter, based on $6.50 per Standardised Whole Patient Equivalent (SWPE) per year.

I repeat the information shown in the May newsletter regarding the tools at your disposal to monitor your progress to target.

Using PenCat, load a recent extract and go to the *Date Range(Results)* filter, specifying which date rage you want to check. Click *Recalculate* and then examine the information under the *Digital Health -SHS Uploads* graph.

If you are running Medical Director 3.16c or later you should have the latest ePIP widget installed on your sidebar. Simply input your swpe figure into the relevant quarter, and the widget will tell you your target and how much was uploaded.

If you are running the Best Practice Lava edition, there is a report available under *Management*, called *Shared Health Summaries Uploaded.* If you haven't upgraded yet, there is a search query that I can make available to you.

I hope it doesn't sound odd when I say that I feel a share of the responsibility for clients of mine that didn't reach a previous target and had to repay the incentive. I'm always happy to refresh the training around this or help practices come up with a new approach.

The eHealth Shared Health Summary (SHS) target on your May payment advice may be incorrect. Log into your practice practice profile online to confirm your SHS target for the August 2017 payment quarter.

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MyHR

A couple of very quick facts around the MyHR progress nationally:

- Almost 5 million Australians now have a MyHR
- Over 2.3 million clinical documents now on line (mainly SHS and Discharge Summaries)
- 921 Hospitals and Health Services connected in some fashion
- Sonic set to start uploading investigations from one of it's Laboratory's
- 20% of Tasmanians have a MyHR
- Only 14% of Australians over 65 have a MyHR !

The last point is really interesting. Even some fairly MyHR-reluctant GPs would often acknowledge the obvious benefits of an electronic record for the elderly, particularly the grey-nomad types. Yet we have a situation where this group has the lowest take-up for the MyHR. The obvious point that would be made would be a comparative lack of technology "comfort" for this age group, but the fact that remains is that the demographic that would benefit the most by the MyHR, is the least represented. Is it just a case of needing a different type of conversation for these patients?

eReferral

Specialist documents delivered electronically are now running at over 9000 per month statewide. Here are the latest updates additions and changes to the published list of electronically referrable specialists.

New

New Town Skin and Repair Clinic		*ntskincr*
Dr Sanda Smith	Paediatrics	*lincolnc*

Whilst progress continues to be rapid in this area, I still hear occasional reports of a practice, claiming not to have received a document, despite all indications from the specialist end, that the document had been sent and received. Interestingly this seems to happen more at practices using Medical Director. This has occasionally led to some strained exchanges between specialist practice and GP staff.

To this end, I would again urge practices to ensure that both admin and clinical staff are familiar with the Medical Director screens around electronic documents. The article on the following page should assist with this, and as always, I'm happy to visit the practice and refresh people's understanding.

PenCat

Active and Inactive Conditions

If you are seeking to identify a particular patient cohort by disease type, you are probably aware that the PenCat tool collects it's data from the patient's Past Medical history screen in either Medical Director or Best Practice. Usually only conditions that are marked as Active are taken into account, however certain conditions that are marked as Inactive are also collected. For example PenCat will consider that a patient suffers from Anxiety even if the condition is marked as *inactive*, whereas only an *active* condition of Depression will result in the patient being identified as suffering Depression.

For a list of these nuances, check the mapping document for your clinical software here.

Templates

No new templates for me this month, but there is a new one for Tasmanian Community Care Referral (formerly TasCarePoint) at the PHT website

As always let me know if you need any created, or need assistance importing templates.

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MD

The facility that enables electronic delivery of specialist reports directly to the doctors holding file, means that a GP could be reading a specialist assessment hours after it has been created. This is obviously very helpful in terms of patient care, along with cost savings in postage for the specialist and scanning and handling for the practice staff.

So it's helpful for practice admin stuff to understand the receiving process, here are some tips.

1) You **do** have Healthlink and it **is set-up** to receive documents. Practices running MD or BP in southern Tasmania especially have been receiving hospital discharge summaries this way for years.

2) You should make a note of your Healthlink address in case someone asks.

3) Specialists receive an acknowledgement message when your system receives the document

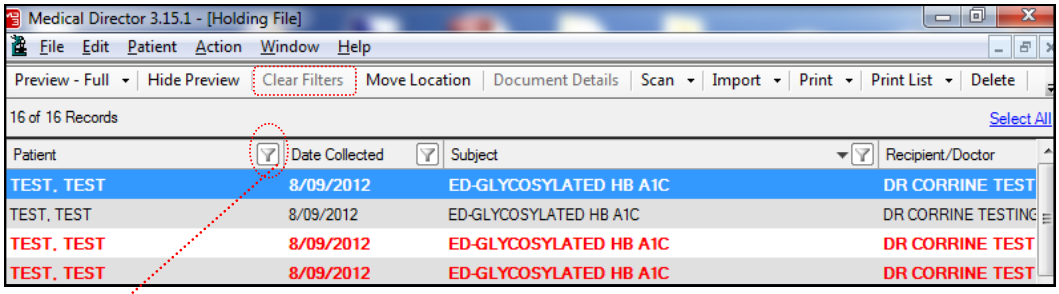
4) There are only 2 places you need to check to see whether a document has been received:

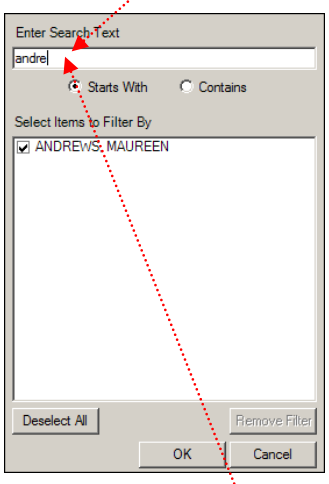
i. Documents not yet checked by a GP, under the *Correspondence* menu, check the **Holding File**.

ii. Documents checked by a GP, under the *Correspondence* menu, check the **Actioned Items**.

Anything that is in Actioned Items is also in the patient record, (instructions below)

5) Although electronic, it is not instant. Allow 60-90 minutes from the time the letter is generated at the specialist before it will show in the MD Holding File.

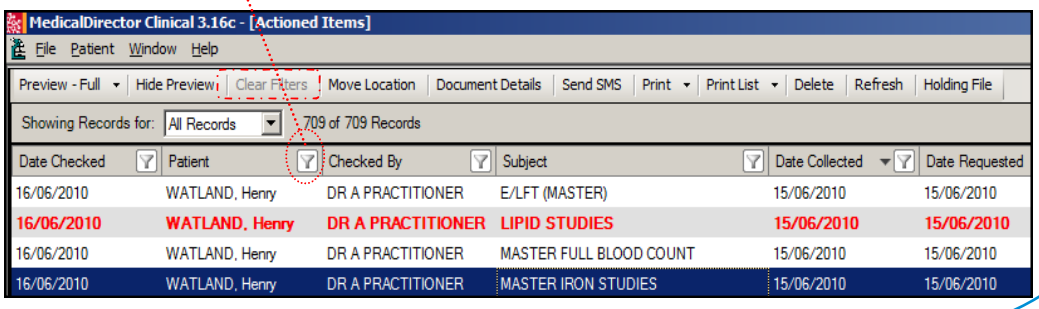




When checking the Holding File (above), select *All Recipients.* This will ensure that all documents are displayed, including ones that are just addressed to the practice.

Click on the filter button at the top of the *Patient* Column, and start typing in the patient surname. If the name doesn't come up, then there are no document waiting to be checked. If the name does come up, simply select and click on *OK*. The holding file will display only documents for that patient. When you have finished, click the *Clear Filters* button to show all patients.

The Actioned Items (below) is used in almost exactly the same way. If the patient has multiple documents, click on the *Date Checked* column to sort them in date order. This list also displays who checked the document and when they checked it as well as the *Location* in the patient record that the document is stored in.



BP

To support the ongoing uptake of electronic correspondence by Specialist practices, it is important that administration staff have an understanding of how Best Practice works in respect of receiving these messages.

It is worth reading the first few lines of the previous article if you haven't already, as some common misconceptions are cleared up. The points made apply whether you are using Medical Director or Best Practice. The following section contains Best Practice specific instructions.

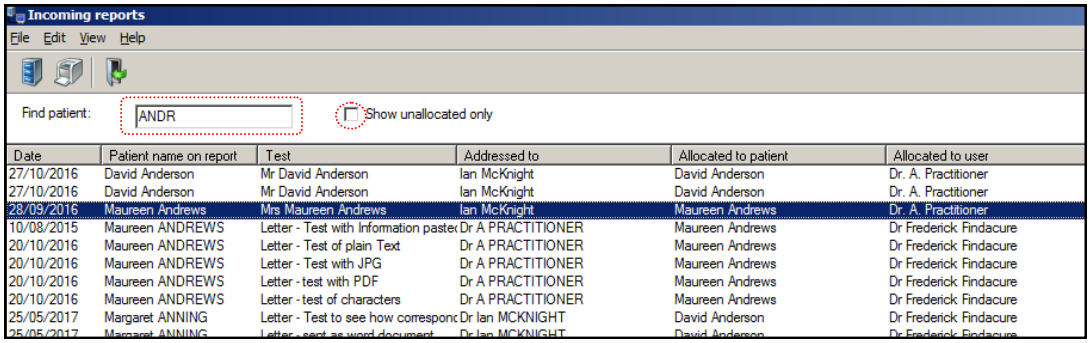
There are only 2 places you need to check to see whether a document has been received:

i. Documents not yet checked by a GP, under the *View* menu, select **Incoming Reports**

ii. Documents checked by a GP, under the *View* menu, select **Investigation Reports**.

Incoming Reports

As stated above, items on this list are all the documents that are sitting in GP Inboxes, prior to being checked and stored in the patient record. There may also be *unallocated* items, i.e. documents that the system cannot allocate to a specific GP, due to the document being addressed to the practice name or documents that BP cannot match to a patient name in your system.



Type the patient surname in the box provided to see if they have any documents waiting to be checked

Investigation Reports

This list details all documents that have been checked by a GP. Note the ability to set a start date. Use the F2 button to select a patient name, and list any documents for that patient. The *Date Checked* field will help narrow the search down.