

# PracSavvy

Clinical Systems Support and Training

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## November 2022 — Newsbrief

Welcome to this month's PracSavvy newsletter. It's been a month that's been characterised by news reports of widespread data breaches. Suffice to say if you are an Optus customer with health insurance through Medibank and have recently had bloods done at Medlab, well you could be forgiven for feeling pretty twitchy right about now.

Speaking of data, I was pleased to read very recently that an overwhelming majority of THS staff (over 90%) regard the MyHR is something that is very helpful and will save them time. I've mentioned before, just about every young GP that I have encountered echoes this sentiment, although I still get a bit of a sense that they only go there looking for confirmation of medications.

On medications and MyHR, I've also noticed that the THS is sending out electronically a document called a [Pharmacist Shared Medication List](#) (PSML) as well as uploading it to MyHR where the patient has one. This document becomes another *source* for medications information in the [Medicines Information View](#) in MyHR as well as being a stand-alone document in the GP InBox. I'm embarrassed to say I'm not 100% sure what the PSML offers you above medication information contained in a discharge summary. If there is something significant, I'd love a GP to [drop me a line](#) and let me know.

On another MyHR related note, [HealthDirect](#) has added MyHR access to its [app](#), making it by my count, the 4th app that has this access. On the subject of apps, the completely immature side of me (which is largely dominant) wants to give a big shout out to Asthma Australia for the naming of this [mobile app](#).

I was very pleased to be able to participate this month in a couple of one-percenters, that whilst tiny could make things a little easier for GPs for years to come. By way of background, when the scanning pile was higher than some of your more *vertically diverse* staff members, the processing of these documents allowed for some specific admin labelling as to what they were. The downside of electronic messaging meant that the document description had to be extracted by your software from the Message Header of the incoming message. The contents of that message header would be governed by either the set-up of the sending provider system and/or the actions of the human document creator. As an aside, MD does a lousy job of extracting useful header information, BP does this better.

Anyway, this is what's been fixed:

Reports from the Menzies Institute are now shown as *Bone Density* rather than *Consultation Note*

This is what is hopefully fixed by the time you read this (or shortly thereafter):

Routine mammograms from [Breastscreen Tasmania](#) are now shown as *Mammogram (RRS)* rather than *Return to Routine Screening*

The aim is to make it easier for GPs, now and in the future, to quickly spot these items in what might be a long list of documents. The more descriptive labelling also facilitates audit tools like PenCat and software reminder prompts to recognise when a scan or investigation has been done.

Deserved shoutouts go to the following parties in bringing these changes about:

Dr Sue Hampton for raising both issues and illustrating with accurate examples.

Carol Ramsay at the THS for being 100% responsive to the request for a GP optimal message

Maureece from the Medical Objects helpdesk who was super efficient in confirming that the Menzies issue would be remedied by an upgrade to their word plugin that would offer more report name choices. Actioned my request promptly demonstrating an A grade support ethic.

Of course there is more to do. The guys at St Helen's have identified that certain documents from the LGH actually show as being from the RHH. It took some convincing of the THS that this was their issue and not a practice one. Hopefully in their newly enlightened state they will get it fixed.

I have also approached Calvary specialists requesting that something other than *Letter* as a description of their documents would be helpful. I made this request with all the associated "clout" of a sole trader with one facebook friend. Well you never know!

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## Templates

The following new or updated templates are available at my website [here](#):

- ◆ Eating Disorder Plan Review (Inside Out) (*modified, not created*)
- ◆ PSB - Application to administer Schedule 8 Medications etc
- ◆ PSB - Application for Review
- ◆ PSB - Notice of Drug Dependency
- ◆ PSB - Notice of Termination of Authority to Prescribe

## eReferral

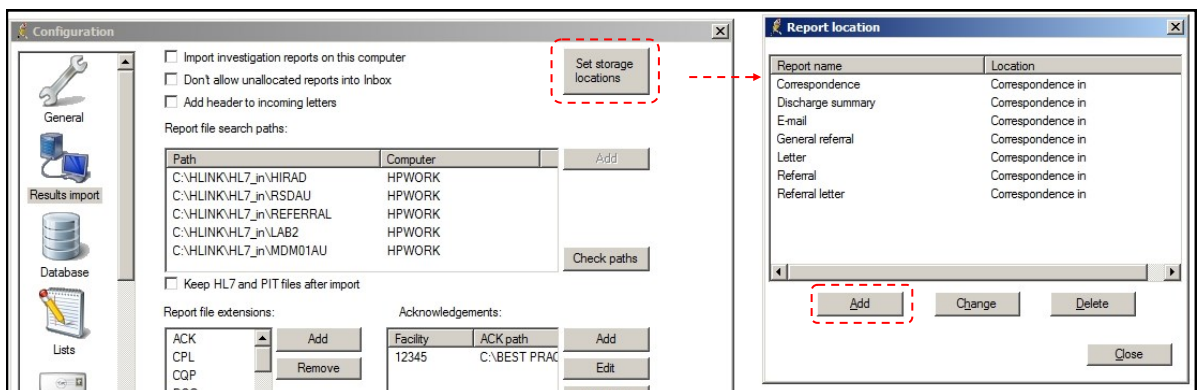
Please update your address books with the following changes, remembering my full list can always be found [here](#).

Dr Eleanor MacMorran    Infectious Diseases    St John's Sessional    *chctlvcs*

## BP

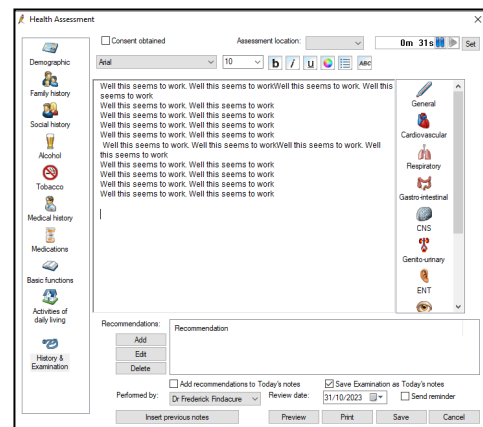
I mentioned previously and on page 1, the issue of documents that are unhelpfully labelled, so it's worth mentioning a tip emailed in from local GP Dr Paul Luckman who was reading my newsletter at Heathrow airport (that's right I have international readership!). He mentioned his practice of moving documents from *Investigations* to *Correspondence In* via the right-click menu. Here you have the option of editing the document details whereby you can rename and then move back into the Investigations folder. I have since suggested to BP that the *Details* button that is available in *Correspondence In* should also be available under the *Investigations* folder.

Something keeps coming up from BP users regarding where incoming electronic documents are stored in the patient record. Please don't hassle the THS about this, it is something that is totally within the practice control. Ascertain the specific name of the document type, then go to Setup..Configuration..Results Import..Add. You can then specify whether you want this document to default to *Investigations* or *Correspondence In*. Remembering that you can also always override this when checking in the *GP In-Box*.



Practices have different ways of conducting Health assessments, some use the module under *Enhanced Primary Care* as depicted, some use a word processing template and some like to have a complex *autofill* that prompts for the required information.

Rural practice nurse Niall has realised that your autofills work well within the History and Examination window of the module. So using an autofill within the module gives you a neat way to easily add further detail to the assessment whilst still employing the convenient process flow of the module.



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## BP

While I'm on the subject of *Autofill*, and actually this applies equally to the MD equivalent *Comment*. Whilst these can be selected from a long list that get's progressively longer, the real utility in these is that you can insert a much bigger piece of information by keying a **brief** shortcut in your notes.

Some practices though, seem to have forgotten the key thing about a shortcut, namely the "short" bit.

So this is not a shortcut:

*75yearHealthAssessment*

This is a shortcut:

*75ha*

Seriously if your shortcuts are brief and easy to remember, you won't have to scroll a long list looking for them. So, without wishing to harp, make your shortcuts short!

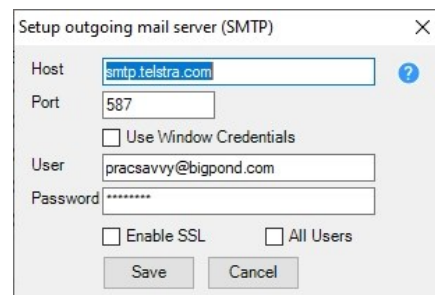
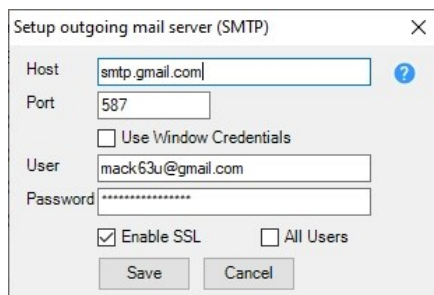
## MD

I know there are some MD users that only read the MD bits and the same with BP users. Suffice to say, MD users should glance at the preceding article as it applies to both systems equally.

In the [June 2020](#) issue I mentioned in some detail the ability to send emails from *Letter Writer* in MD. I mentioned at the time that for this to work, an email program and account has to be set up on the pc or login profile of the user for this to work. MD merely interacts with what is set up on the pc. This remains true, but I have to add to this that it is also possible for this to work with a web based Gmail account. I don't know if it also works with web based outlook accounts, but as Gmail accounts are free and really easy to set up, it's worth highlighting this.

So for the account to work with a Gmail account you will need to set up an app password as per the [linked instructions](#). When you have created the password, this is what you must paste into the configuration screen under File..Preferences..Advanced in *Letter Writer*. Actually to create this app password in Google, you will need to enable 2 step verification for the account.

Getting it working was a little fiddly, but I've shown below 2 configuration screens that worked for me. First using a gmail account and second using a standard smtp bigpond account.



Now email of course isn't 100% secure, so entirely up to the practice whether they embrace this. Personally I would be fine with using this to communicate with patients, once I had advised them of the small potential security risk. BP users are enjoying the fact that their documents that are emailed take the shape of pin number protected PDF files. Unfortunately with MD it's just an attached rtf file. Practices can decide what level of risk they are comfortable with.

It looks like data dashboards are coming to MD. The first step seems to be Smart Visual Dashboards that can be accessed via Pracsoft, and you can read about them [here](#) as well as watching a brief video. If you are happy to participate in a deidentified data research project, you can access for free.

Actually as an aside, at the time of writing there are problems with these dashboards and they are not working. I know this because I monitor the site [here](#) as well as receive email notifications. **YOU SHOULD TOO.** In a rare step forward for MD, they now have a website showing any system difficulties they may be having as well as sending out email alerts. A little while ago, I (amongst others I'm sure) let them know that it wasn't good enough that there could be a known issue that a practice manager may have to wait hours on hold just to find out about. This was happening around the country. Happily now there is a [system status](#) website as well as an email subscription service. Kudo's to MD for improving their customer service.

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I've always encouraged clinicians to pick from a coded list whenever possible when entering a *Reason for Visit* or *Reason for Prescription*. The reason for this is twofold, firstly any newly entered conditions are cross referenced with the current medications list looking for any possible contraindications. Coded entry also means that any database searches for patients of a certain cohort are going to be more reliable.

Recently, when conversing with an intrepid fore-mentioned practice nurse, he mentioned the paucity of coded options available when dealing with a patient who presented with an infected leech bite. In the interest of clarity, I mean a leech bite that had become infected, not a bite from an infected leech. Although as far as I know, nobody had checked on the welfare of the leech. QI issue for the practice perhaps?

Thinking about this further it did motivate me to investigate the coded "bite" related options available in the main GP software programs.

## Best Practice

Reason for visit - Mr. Darren Anderson

Search:

Reason for visit

- Bite
- Bite, animal
- Bite, ant
- Bite, bat
- Bite, cat
- Bite, dog
- Bite, fish
- Bite, goanna
- Bite, human
- Bite, insect
- Bite, mosquito
- Bite, rabbit
- Bite, reptile
- Bite, sandfly
- Bite, shark
- Bite, snake
- Bite, spider
- Bite, tick
- Bite, turtle

## Medical Director

Enter reason for contact

Pick from list (coded)

- Bite - Animal
- Bite - Arthropod
- Bite - Cat
- Bite - Dog
- Bite - Human
- Bite - Insect
- Bite - Marine
- Bite - Redback Spider
- Bite - Snake
- Bite - Spider
- Bite - Tick
- Bite - Unknown origin

BP has the larger list, unsurprisingly, and probably just edges the MD list in terms of *Australiana*. They've got you covered if you are bitten by a Goanna, and some poor GP at some point must have been so inundated by patients with turtle bites that they requested it to be added to the list. I mean, it can't have been there by default. *Bite, bat* was apparently requested by a Chinese doctor, not sure why though, as I thought it was a *bat* getting *bitten* that started the whole pandemic thingy.

BP has its origins in Queensland of course, where the rabbits must be waaay more savage than any I have encountered, possibly they're still miffed over that whole [myxomatosis thing](#) in the 50's. Still does seem odd that a rabbit is listed, but if you're savaged by a dingo or quoll or Tassie Devil, you are on your own with free texting. Camels, notoriously bad-tempered don't get a mention in either list. You don't hear about them as much these days, but Camel used to be a popular [cigarette brand](#), giving rise to the old advertising punch line, *9 out of 10 men who have tried Camels prefer women!*

The MD list had a couple of things that caught my eye, starting with *Bite-Arthropod!* Now I'm not sure what percentage of the population knows what an Arthropod is, and it's possibly slightly higher in the GP demographic, but not much higher I would imagine. I of course, immediately recognised the taxonomic label for multi-legged crawly things, but I still think "I've been bitten by an arthropod!" is more likely to be heard in a Dr Who episode than in a Dr's surgery. Redback Spiders get a specific mention, but not the much deadlier Sydney Funnel Web. This may be because a bite from the latter is more likely to be documented at an autopsy than a GP consult.

Lastly if you are bitten by a Marine, you get a drop down entry, but if a paratrooper, sniper or infantryman sinks his fangs into you, then free text is the GPs only option.