PracSavvy

Clinical Systems Support and Training

www.pracsavvy.com.au

November 2020 — Newsbrief

"The way to cope with the future is to create it."

This was apparently a quote by a scientist who won the 1977 Nobel prize for chemistry, and it's been used in varying forms by others since then. It has sometimes been attributed to Abraham Lincoln, although I think that has been debunked. Nobody so far has attributed it to President Trump!

I think it applies strongly today. Certainly we live in changing times, and the prospect of change often conjures up fears and hypothetical disaster scenarios. I like to think of the idea that taking positive pre-emptive steps puts us in with a far greater chance of being in control of our future. In the last few weeks I've seen an example of one practice who has applied this thinking, and have come across a couple of scenarios where this approach should apply. One scenario is upcoming for all, and the other has been a potential outcome for a long time.

Example 1 I was going to briefly whinge about that fact that escripts in Tasmania had ground to a halt, with the exception of generally speaking the Launceston and Devonport areas who were lucky enough to be considered a Community of Interest or as they are now known an Active Area of Implementation. You may recall that Best Practice released the software needed some months ago (after being asked to fast-track it's development), and were then forced to withdraw it, apart from to practices in these designated areas. MD arrived with their update, and have been selectively been making it available through Victoria (Covid) and more recently NSW. I suggested Tasmanian practices apply to have their locality classified as above, but those that tried ran into a bit of a brick wall.

Then, a few days ago one of the most proactive practices that I know, got a phone call from Best Practice out of the blue, giving them the green light. (*note the skilful use of 2 colour metaphors in the same sentence!*) Some months ago, this practice had started talking to their local pharmacies confirming that they were escript compatible. They had been keen to implement escripts and had done everything asked of them, only to be told to wait. So it was great news that despite not being a designated area they were eventually given the go ahead. All because they took the initiative and decided not to wait for the slower wheels of bigger organisations and bureaucracies to turn.

Example 2 The Digital Health agency recently re-designed it's training web site, with one consequence being that I had to recreate my password. The criteria for an allowable password was: *The password must have at least 14 characters, at least 1 digit(s), at least 1 lower case letter(s), at least 1 upper case letter(s), at least 1 non-alphanumeric character(s) such as as *, -, or #.* Is it just me, or is that way over the top for a website that just offers free training courses?

But Practice passwords continue to be an issue, specifically the case where many or all users have the same password. I won't deny that occasionally that scenario has been handy for me when working with a practice manager to look at or solve a GP related problem. But the reality is, everyone having the same password is ideal for the unscrupulous person wishing to hide their tracks, not to mention the possibility for suspicion to fall on staff who have **done absolutely nothing wrong.**

Now, I am no fan of organisations or people who use threats of doom or legal consequences in order for you to buy their product or accept their premise. Fear based hypotheticals generally irritate me. Having said that, I have heard extremely credible accounts of precisely this scenario playing out in plural Tasmanian medical practices over the last couple of years, where one apparently totally unscrupulous operator has taken advantage of identical passwords to conceal their dishonest activities. **So invest in future safety, protect your business and your staff and fix those passwords!**

Example 3 It's time to start mentioning in this publication that from February 1st, Active Ingredient Prescribing (AIP) will be compulsory in Australia. I will talk about this in detail, probably in January, but what it means in a nutshell is that all scripts (with a couple of exceptions) will have the *active ingredient* mentioned first on the script AND that any mention of *brand* or stipulation barring *brand substitution* on the script will only occur as a result of the GP ticking the boxes in the software on each occasion a new original script is generated. GPs will still be able to select by brand name, but the physical script will be different.

Continued..

I imagine the biggest worry will be patients who are used to asking for a brand name, suddenly seeing words they don't recognise on the script. Hopefully there will be some sort of government led public education over the next three months. Of course, we know that hasn't always worked out so well, e.g. MyHR. They may also leave it to clinicians and pharmacists to educate the public on the changes, but historically that hasn't worked so well either, e.g MyHR. So I'm suggesting, if you can see drama in February, your practice may want to start thinking now of ways to avert or lessen the issues. Your GPs will be emailed stuff that they may or may not read, but there is a good quality product-neutral panel discussion video that MD have available here.

On a completely unrelated and happily less preachy note, I like occasionally to give a shout-out to reception staff who as we know bear the brunt of public frustration and personality quirks whilst taking home a distinctly non-medical pay packet. The following video may give them a laugh.

Templates

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

- THS Specialist Palliative Care Referral

If you have recently updated Best Practice to Jade SP3 or SP4, you may have noticed the strange disappearance of the Veterans Affairs DB904 form. This caused quite a stir around the place. You can download the new version in BP or MD format courtesy of the Adelaide PHN website

eReferral

Please note the following providers that can now be corresponded with via healthlink. The full listings are available on my website here:

Dr Frank Kimble   Plastic and Reconstructive Surgery   *hobplast*

Hobart Breast Implant Clinic

Several years ago, a new and rare risk of having textured breast implants was identified.....Anaplastic Large Cell Lymphoma. In the beginning, little was known about this condition but as cases mount, our knowledge and awareness as Surgeons has increased to the point that The Australian Society of Plastic Surgeons now recom-mends an annual review of all patients with textured breast implants inserted for cosmetic and/ or reconstructive purposes. There is a large cohort of patients in Tasmania who fall into this category, andIt was with these patients in mind that the Hobart Breast Implant Clinic arose.

Hobart Breast Implant clinic was established by Mr Cameron Keating and Assoc Prof Frank Kimble and is going to be run by Frank Kimble, a Plastic Surgeon with almost 30 years' experience as a Specialist Plastic and Reconstructive Surgeon. The Clinic offers review of patients with breast implants, but Frank will also see patients considering having breast implants, or those wanting breast reduction or breast lifts.

Hobart Breast Implant Clinic is situated within Cameron Keating's Rooms at the Hobart Institute of Plastic Surgery, 34 Argyle Street, Hobart. Patients will require a referral from their GP to be assessed in the Clinic.

P: (03) 6214 3572 F (03) 6214 3573 Email: clinic@hobartplasticsurgery.com www.hobartplasticsurgery.com

A topic that bubbles along occasionally is whether documents need a physical or scanned signature, there is much ill-informed opinion on this. It is often a matter of what the recipient is happy to receive rather than any actual hard and fast law. In reality a scanned signature is no more binding or effective than the name of the requestor typed at the bottom of the page. Either one is regarded as an *electronic* signature.

Certainly referrals sent via Healthlink are considered *digitally* signed, which is the top standard as far as security is concerned. It's often hard to source Medicare published information on things like this, but I recently found this link confirming that electronic pathology requests do not have to be signed.

PracSavvy

Clinical Systems Support and Training

www.pracsavvy.com.au

Nursing

The last week has seen the launch of The National Nursing and Midwifery Digital Health Capability Framework. It's basically a structure enabling Nurses and Midwives to identify their digital health capabilities as well as areas for potential improvement. One of the leads for this project is Dr Helen Almond, a name some of the southern practices may well recognise. There's no doubt that between Telehealth, MyHR and many other initiatives, we are bringing far more digital technology to bear on healthcare. This programs allows nurses to formalise and document their understanding of the prevailing technologies.

There is general information including a set of brief videos to be found here.

MyHR

Specialists have been almost the last cab of the rank as far as being exposed to MyHR goes. This month however, the Audit 4 program becomes the first specialist software to reach full integration with MyHR. The other major players are expected to follow early next year.

It remains to be the case that any time I corner a Dr or nurse and illustrate some of the utility offered by the MyHR, they register surprise at the usefulness of what they can access. Admittedly it's often young interns or registrars who are to polite to tell me to go away, but the fact remains, you are missing out on helpful information if you are not familiar with accessing this interface.

Covid has been a stimulus in this area, and the latest statistics point to growing usage:

- 99 per cent of pharmacies are registered and 87 per cent are using the system
- 94 per cent of GPs are registered and 84 per cent are using it
- 96 per cent of public hospitals are registered and 94 per cent are using it
- there are 22.78m records with 75m clinical documents uploaded and 143m medicine documents
- hospitals have uploaded 406,000 documents that have been viewed by others and hospitals themselves have viewed 386,000 documents that have been uploaded by others
- GPs have uploaded 253,000 documents that have been viewed by others and have themselves viewed 504,000 document uploads by others

MD

Medical Director took me by surprise this last month when they unveiled a new cloud based care-planning tool that they are calling MedicalDirector Care. I've always thought Care Plans, and particularly Team Care arrangements represent a logistical challenge for General Practice, especially if you adhere strictly to the rules around separate and individual invitations to external team participants. Nevertheless practices have gone through the pain and found a way to make it work for them. For this reason I always feel that anyone bringing a new product to market in this area, and saying to practices, 'abandon your current system and use us' better have a pretty special program on offer.

I'm not sure that this is the case here, but that's based on a fleeting look, and I'm certainly not accustomed to creating care plans. Similar to the more mature Inca program, (formerly known as CDMNet), MedicalDirector Care imports the patient's health information and your local address book to a secure website. Unlike Inca, it does not offer the interface to external plan participants as far as I can see.

You then create the plan using your web browser. I was not able to be as left to right fluent as the presenter in this demonstration webinar seemed to be, rather finding myself going backwards and forwards. That may be entirely my fault though, and I was using their mega multi-disciplinary template. (I intend to create a couple of plans, for a more comprehensive review next month)

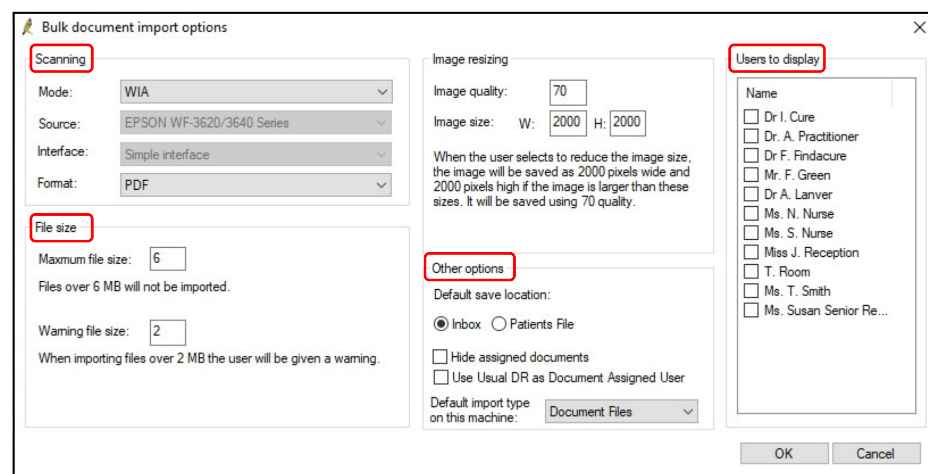
I tested it using the Firefox browser which only a small percentage of pc users use, next month I will try Chrome for a fairer representation. I found my pop-up blocker blocked some of the documents that the program was trying to show me and also the data input sometimes displayed on top of the field name, making it unreadable. I also found it strange that when specifying a review date, it didn't write back to MDs recall system. On the other side, a practice wide-dashboard of the status of all care plans was a nice feature. The documents that were created at the end of the process and saved to the MD clinical record were nicely designed and easy on the eye. More detailed information next month…..

BP

These days most practices are in the good habit of scanning faxed or mailed documents straight to the GP Inbox for checking. In my ~~humble~~ opinion, this is far more sensible than giving it to the GP, waiting for it to come back and then scanning it. It means that the document need only be handled by front desk staff once, before it becomes part of the electronic clinical system. This isn't the end of the story though as far as document processing goes. This article will focus on the desirable situation where documents are scanned in the right format and in doing so are saved at a file size that is no bigger than it needs to be.

This focus on saved document size, means that our saved documents can be retrieved more quickly, that our document databases will increase in size more slowly and that future requests for patient records or subpoena information from other parties will hopefully result in smaller size files needing to be transported.

Documents are saved to the GP Inbox via the Bulk Document Import Utility (BDI), which can be found under the start menu and hopefully as an icon on the desktop for those who do the scanning. The first thing to do is check the *Options* under the *File* menu.



It's important to note that these settings are per user, so they should be checked for everyone who is importing or scanning documents. Key Settings are:

Scanning- *Interface:* I would be inclined to pick the *Simple Interface* value here. This gives you the basic BP interface rather than the scanner software one. The scanner one may give you more features, but unless you are a real scanning pro, the simple interface means less chance of scans that are too big.

Scanning– *Format:* PDF is the format to select if the majority of what you are doing is scanning documents rather than pictures. This format will invariably create smaller file sizes than a graphic format like tiff or jpg.

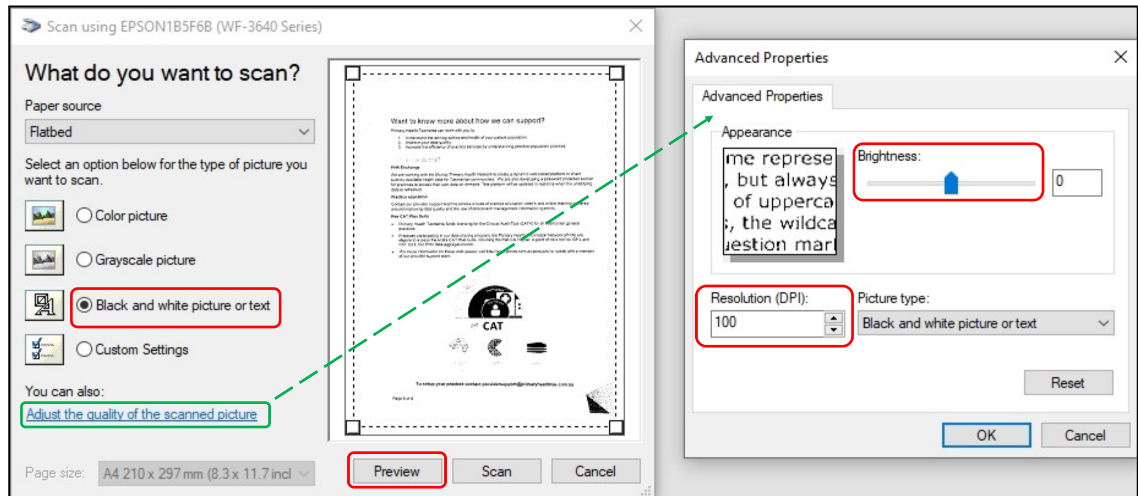
File Size: This helps prevent you create files that are too big, as well as giving you a warning once they exceed a certain size. Note, if you have a 50 page document, it's going to be bigger, what we are trying to prevent is way too big file sizes for small documents.

Other Options: Select the Inbox as the default storage location, because this is where most of your scanning is going.

Users to Display: If you are only scanning to GP Inboxes, then why would you want all the other user's names to display when you are allocating the document. If you tick nobody here, then everybody's name will be displayed when you are looking for the GP Inbox. If you are an admin staff member in a multi-branch practice and have missed this setting, this tip alone should earn me your undying gratitude. ☺

Once you have checked these settings, you have the bedrock for an efficient scanning process. Let's now look at the choices when you scan the document.

Clicking on the Scan icon invokes the dialogue at below left. Clicking the *Adjust the quality..* link displays the dialogue at right of screen.



Despite the emphasis on *size matters* in this article, I should stop here and say that we are really trying to achieve is a scan of a document that is viewable in BP practice and would also be perfectly legible if printed out. Not necessarily immaculate but certainly legible. Generally speaking the optimal way to scan and store these documents is using the *Black and white picture or text setting* as highlighted above. If the quality of the original is a little compromised, the *Adjust the quality of the scanned picture* link reveals some advanced settings where you can tweak the brightness or increase the resolution from the normally adequate 100 DPI.

Back in the main window, you will be able to tell how legible the document is, (unless you have checked *Hide assigned documents* in the options area) . If the original is that bad that the scan is inadequate, you may want to try scanning again with the *Greyscale picture* setting. This will result in an actual full photo being taken of the page. If you do this though, you may want to go back to the options and change the file format to *jpg* for this document, as this will create a far smaller file size.

When you have decided on the scan format, the final step is filling out the message details as per the cropped graphic below.

The document is defaulting to the Provider In-Box. Because we just ticked Dr names in the options box, those will be the only names displayed in the user field.

Diligently completing the remaining fields will mean that the document can be easily identified and retrieved from the patient record in the future, should that be required. When finished, click the OK button at bottom of screen, (not depicted)

These last settings are also used if we import a file that may have been delivered by email or efax.

File 1 of 1 (PDF File)
Store in: Inbox / Patients File
Patient: Miss Jessica Cate Allen — Search...
22 Star Street
Fremantle 6160
DOB: 08/01/1992
Date: 2/11/2020
Subject: Report
Contact: Dr Colin Chia — Search...
Store in: Correspondence In
User: Dr F. Findacure — Default
Category: SPECIALIST LETTER
Report
Specialist letter
Messages and other functions
Scan/Import another page: Scan / Import
Use last entered settings for this file: Use last settings
Copy the above settings to all the files currently in this wizard: Copy to all files
Delete file after importing — Delete all files

Ian McKnight t: (03) 6247 1178 m: 0418 336 804 e: pracsavvy@bigpond.com