PracSavvy

Clinical Systems Support and Training

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September 2022 — Newsbrief

Welcome to this month's PracSavvy newsletter.

August saw a few things happen that helped generate a bit of a theme for this newsletter. It's always informative when Doctors or practice staff get in touch to highlight what may not be working as intended with their software, or what needs improving. It's also enjoyable when they share some tips that they have come up with to make life easier or their processes more efficient. It helps foster the idea of a healthcare community helping each other, and I'm definitely a fan. Keep reading this newsletter for the good stuff.

On a related non-software note, there was an article published on the RACGP website about Dr Bailey Dunn and the John Street Medical centre and how they had managed to combat and prevent burnout for staff and GPs whilst generating a 20% increase in profit. It makes for an interesting read, although I don't know if there any truth in the rumour that some of the GPs down there have indicated they may be able to tolerate a teensy bit of burnout in return for 30% profit!

Another interesting development is that UberHealth has landed in Australia. Roughly speaking someone at the practice reserves a Uber ride for a patient's future appointment using a web based dashboard. Apparently Uber will text the patient whilst the driver is on the way to pick them up. Check the website if you want more details or just read the FAQ.

August also saw the evaluation report of the Health Care Homes Evaluation Trial released. I don't know how many practices stayed the course of this trial or whether the "trial" descriptor was both accurate and ironic. I imagine the pandemic may have also have been a significant spanner in the works. If you want to know more than I do, you can read the summary or the whole report here.

Healthlink have advised that they have a new software client that is going to be released as a software update progressively over the next few weeks. It promises bigger message sizes, but unfortunately not for the referral type messages that General Practices generate. The new version is 6.8, and hopefully the automated roll-out won't result in any message transfer disruption.

Still on Healthlink, I'm now told that the next lot of THS clinics to be added to the Healthlink ereferral Smartform choices won't be available until November, and even then it will be restricted initially to clinics in the NW. This feels like the 3rd or 4th time that the deadline for an addition to the 2 southern and 1 northern clinics has been moved, and I have to say I am disappointed. The majority of the work it has to be said is at the Hospital end, but the minimal amount of clinics on offer is a key reason why there isn't higher GP uptake for mine. Given that the initial trial for this commenced a good two and a half years ago, it's a real shame that what could be a significant and obvious process improvement is moving like treacle. If you don't know what I'm talking about, you can read up on it here, but no need to hurry, the page hasn't been updated in over a year!

It doesn't affect Tasmanian doctors but in South Australia the Return to Work template is now a Healthlink form, rather than a word processing template. I remember mentioning years ago that smartform technology would be the perfect fit for those initial and ongoing WorkSafe certificates, in that there is more form type technology than the clinical word processors offer. If any Doctors reading this have a relationship with the leadership at Worksafe, it would be worth giving them a nudge.

It's old news but the THS were the last public health service in the country to give their doctors access to the MyHR . All of the young doctors I have spoken to have indicated how helpful to them this is…..surprise surprise! Now the generally glacial THS have a youtube video actually promoting the MyHR. If you have 3.5 minutes to spare, you can watch it here. I don't know that they've fully got the hang of YouTube, they've strangely and unimaginatively called it *My Health Record animation*, but hey the thought is there.

On a Federal level, a couple of things that may have spooked the horses this month. Firstly it was the ADHA warning people that they have to ensure that they have to have updated to a SHA2 Nash certificate by 31/12 or things will stop working. After the PKI certificate fiasco that consumed so much time and energy in the first half of the year, it's little wonder some practice managers started hearing helicopters reading this email. Truth is most practices will be already running SHA2 certificates, although there may be a couple of MD practices that need to take action. Read on the back page for how to check. ……..*Continue over*

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….Continued.

Secondly there was something from the OAIC that found it's way into some RACGP newsletters around the country, which contained gems along the lines of:

"If you no longer need to retain certain personal information you've collected, it may be time to destroy it. Doing so supports community expectations that the information they provided to support the COVID-19 public health response shouldn't be retained indefinitely and should be deleted as soon as it's no longer needed"

and

"*you should ensure that the digital records are permanently destroyed, including in any back-up system or offsite storage*"

The article seemed to be pitched in particular at practices who had gathered patient information purely for the purpose of vaccinating them. A classic example of knowing all the ideology and none of the practicality, particularly when it comes to modern GP software. I would suggest that the line about community expectation is also totally misguided. One to ignore for mine.

Lastly on a far more positive note, it was announced that federal funding of SMS escripts is to be extended until March 31st 2023.

Templates

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

- *MediHuanna* Intake and consent form
- THS Lactation Consultant Referral

The updated Application to Prescribe templates are now available at the PHT website here.

From the front lines

As I mentioned previously, the last month has seen some really good information sharing from practices, highlighting what could be improved, what is not quite working and what is a smart way to do things.

Breastscreening Reports: As mentioned last month Breast Screening reports began to be delivered to practices electronically via Healthlink, which is a great thing. However one senior GP at the Ochre Hobart medical centre noticed that when the report was stored in the GP software, it wasn't easily identified, with the word *Mammogram* not appearing in the Test Name column and the sender being shown as the Breast-screen healthlink EDI.

As the word *Mammogram* was not shown in the report header information, the clinical software in use doesn't recognise it as such and thus continues to prompt the GP for an investigation that has already been done. Similarly, the investigation was not recognised by the PenCat tool as a mammogram. The actual wording in the test name was/is *Return to Routine Screening*. The GP in question documented this thoroughly with appropriate screenshots and examples. The information was shared with myself and also Breastscreen Tasmania, who certainly received the feedback in exactly the right spirit. These particular issues are often derived from the makeup of the electronic message generated by the lab, and this can sometimes be a bit of a dark art, but it is now being looked into with every chance of an improved outcome. Full credit to the GP in question for documenting and sharing the issue.

Covid-19 Antiviral: The very same practice contacted me asking if *COVID-19 antiviral eligibility assessment* could be added to the coded dropdown *Reason for Visit* down list in Best Practice. I mentioned that whilst we can not manipulate these lists, I could ask BP to add it via their User Forum. So I was delighted that a fortnight later when The September data update was released, it included that very request as an addition to their coding. Well done to the practice for raising it.

***Lost* Contact Notes**: At least some of you may be well aware, that in Best Practice or MD, you can move documents between *Correspondence In* and *Investigation Reports* via right-click menu. (Same thing in MD between *Documents* and *Results*) *Continued Over...*

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However some sharp eyed nurses at Augusta Road noticed that if you moved a document from *Correspondence In* to *Investigation Reports*, you lost the ability to see *Contact Notes* generated while the document was stored in *Correspondence In*. If you move a document in the opposite direction, the error didn't occur, and similarly if you sent the document in question back to *Correspondence In* the notes would reappear.

So there is obviously a problem with the software filters here. The Contact Notes are never lost as you can always see them from *View..Contact Notes* in the patient record. They just don't appear in the circumstances described above when you right-click on a document to view the *Contact Notes*. Note that we are talking about *Contact Notes* here, not the notes that are generated in Today's Notes and shown in *Past Visits*. Knowing this issue exists will certainly help solve some future mysteries, and I have alerted Best Practice to the problem.

AIR Demographic Match: So still with the browny yellow practices, this time in sunny St Helen's where I was doing some training with a new intern. I was going thru immunisations in a test patient record and we keyed in an immunisation. Imagine my surprise/shock when the word *Success* appeared in the AIR Status column in the immunisation record. Turns out that even though the patient was called Rebecca TEST, it was a modified record of a previous staff member, where crucially the Medicare Number and Date of Birth were the real ones of the staff member and this was enough for AIR to generate a record match. From this we learn that AIR demographic matching isn't as stringent as MyHR demographic matching.

Embarrassingly I had to ask one of the practice nurses to contact AIR in order to delete the fictional immunisation.

HotDoc - Resolve in Software: From the same practice came the discovery that if you *Mark as Performed* a *Reminder* in BP or *Update* a *Recall* in MD, outside the HotDoc *synch* window, it won't show as resolved in HotDoc. Typically this window is 30 days after the item is due. The same thing applies if the item in MD or BP is deleted, although I would prefer practices only delete an item if it was created in error.

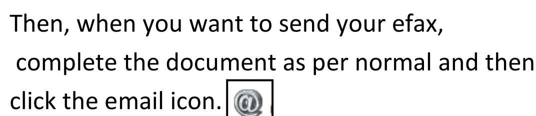
eFaxing: I hope it goes without saying that secure communication via Healthlink should be our first option when corresponding with other clinicians. However if you simply have to fax, I think you may enjoy the following process shared by the ultra progressive (in a good way) Glebe Hill practice.

I'm never really involved in efax setups as this is usually achieved by the practice and It's IT team. However I have noticed a few that seem to involve 2 distinct steps, namely a GP saving a document to a folder with a reception staff member attaching the document to an email sent to an efax provider.

The key enablers in this are obviously an efax provider and ensuring that you have the Best Practice outbound email setup configured. (Sorry MD users, I should have mentioned this 7 lines ago). In the example below, Techquity are the efax provider so we need to modify all our non-Healthlink using Contacts by putting their efax address in the format shown in the email field as below.

We have merely put their efax number in the email field in their Contact details. If you want to keep their actual email address you can copy it to the Comments area. This is handy for a Pharmacy escript email address which can be copied (Ctrl-C) and pasted (Ctrl-V) into an escript dialogue.

Then, when you want to send your efax, complete the document as per normal and then click the email icon.



Make the selections as per graphic on the right, removing the PIN number and clicking *Send*. You have just sent an efax direct from BP.

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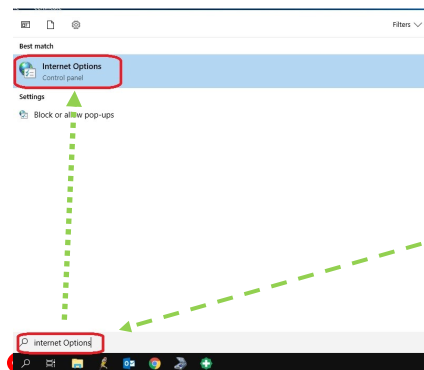
Nash Certificates

Practices need NASH certificates installed in order to access MyHR and also do escripts. Earlier on this year most practices had NASH certificates that were due to expire on 31/3. Depending on which version of their clinical software they were running, the certificate applicant was prompted to request a SHA1 or SHA2 compliant certificate. Suffice to say, most practices had updated their clinical software and therefore downloaded and installed a SHA2 certificate. For them nothing more to do and they can safely ignore the ADHA email from last month. A minority of practices (principally MD users) may however have downloaded a SHA1 certificate, and they need to obtain and install a SHA 2 certificate by the end of the year. For those interested SHA2 just means a more secure certificate protocol, one for the nerds to worry about.

If you are unsure whether you need to update, the following quick guide tells you how to check. Try and do the steps on your server, but a workstation should probably work as well.

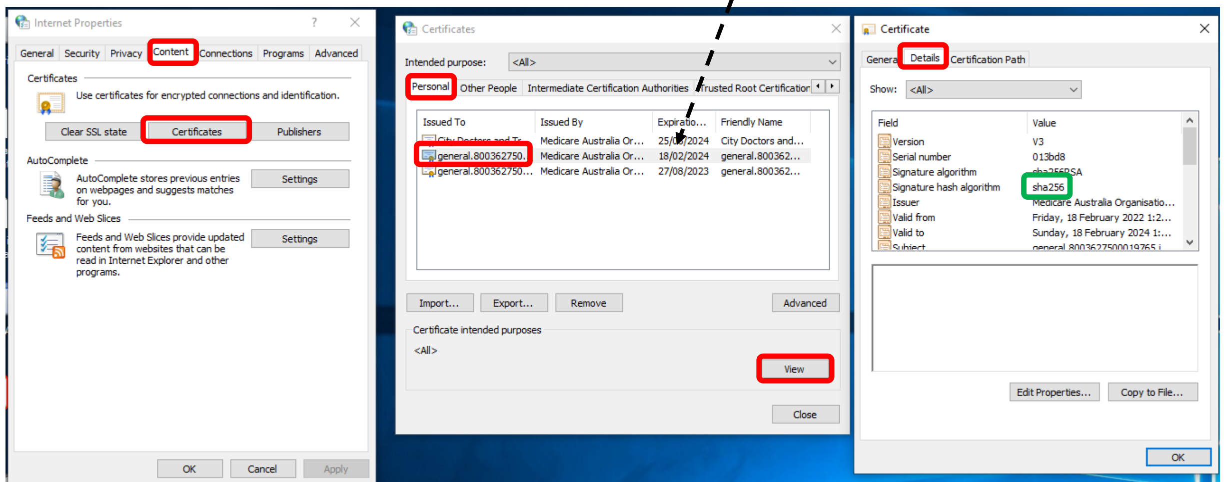
1st



Internet Options

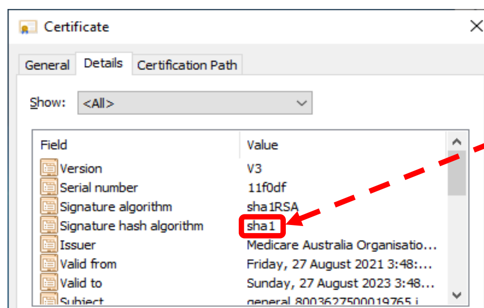
2nd

General certificate with latest expiry date.



All good, nothing to see here. ☺

OR



Just apply for and install a new NASH by 31/12/22

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