PracSavvy

Clinical Systems Support and Training

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September 2019 — Newsbrief

Teamwork is an idea that workplaces have inherited from the sports field. Whilst, particularly in bureaucratic settings the idea can be corrupted in a way that fosters mediocrity or justifies a wasteful or inefficient staffing structure, in General Practice it can be the difference between an efficient business and an inefficient one. It can be the difference between a rewarding career as a professional and feeling like an un-appreciated drudge whose time is not important.

General Practices, unlike larger organisations are not blessed by surplus or unoccupied staff. For patient care to be delivered well, in the setting of a successful business environment people simply have to work together and acknowledge they are part of a team, part of a bigger whole. Whilst our computer soft-ware has become better and more efficient, after working in this area for over a decade, I'm not sure that our teamwork has evolved at the same rate. We need to remind ourselves that teams are comprised of both stars and people who play lesser but important roles. Every Ben Stokes needs a Jack Leach. (Too soon?)

It would be a worthy aim for practices to try and ensure that their Drs and nurses in particular are *employing their best skill sets* most of the time. I'm sure it is disappointing when people find themselves doing activities that require much less skill than they actually have, especially when those activities are only necessary due to another team members lack of care or attention. We need to remember that practices are where some people at least start or develop their careers.

So how can doctors help the nursing/admin staff?

First and foremost, mark things off! If the care has been completed for a recall or reminder, mark it as completed. If a required conversation stemming from a pathology result has been had, mark the item as "Notified" MD or "Given" BP. The reality is that when this doesn't happen, the item in question will remain on an outstanding follow-up list. A patient will either be called back in incorrectly, or another member of the team will spend several minutes investigating an item that warrants no follow-up. This fruitless activity in a large practice could add up to several hundred wasted hours a year as well as a dramatic under-utilisation of a nurse's skills. Clinicians have improved their clinical software usage markedly over the last few years, but it disappoints when I hear that some practice staff have "given up" trying to get their doctors to do this.

Secondly, don't invent your own follow-up protocols or reminder/recall reasons! As far as reminders go, the practice staff have to play their part by ensuring that the drop down lists are comprehensive and contain everything a GP might need. But if a nurse is tasked with sending out immunisation reminder letters, things are far more long winded when they have to trawl for 15 different ways that an immunisation remind-er has been expressed. If you are using a 3rd party program like HotDocs, then any free-texted reminder will require manual intervention from someone else at the practice, in order to map it to a HotDocs template.

As far as pathology follow up goes, if you use MD, your choices of action should be restricted to; No Action, Discuss, Return Urgently and any other term *that the practice as a whole has decided upon*. Your nurses /admin predominantly deal with follow-up by selecting from a category and executing the protocol linked to that category. Whether the practice uses MD or BP the nurses/admin staff should only have 3-6 categories to deal with. It is messy and inefficient when the category list contains dozens of free handed fol-low-up notations. This is not to be confused with the *Comment* field that both programs provide. This is where you can enter clarifications or further instructions and your non-doctor colleagues will love you for putting helpful detail in here.

Finally if you don't know what the follow-up protocols are, ask the practice manager. If no documented protocol exists, then insist one be created.

Continued..

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Continued..

But of course teamwork is not one-way traffic.

How can nursing/admin staff help the doctors

The first thing that comes to mind is templates. I spoke to a GP the other day and he said that every time he does a referral letter he had to remove an incorrect notation from the letter. He had been doing this for months, and yet fixing it in the template took me 20 seconds. Our GPs should not have to spend any of their time fixing letters that arise from template errors. I would urge the practice staff to undertake the following actions regularly.

- Check you have the latest versions of form based templates
- Ask your doctors if any of the templates are causing problems and fix them.
- Go through the list and generate documents as if you were a doctor. You are checking for ones that don't auto-populate properly and ones that don't print out as intended.

Templates that don't auto-populate properly have been imported incorrectly, or may have been inherited if you migrated or merged clinical systems (e.g. MD to BP). If your MD documents are not centred on the page, it is because MD ignores margin settings when you import a template, so fix these. If you get updated versions of templates, labelling them with the date is an easy way to tell that you have a recent version. Fix 1 template so your GPs don't have to fix dozens of generated documents.

Recall/Reminder choice lists should contain all the reasons a GP might need. If we don't want GPs free texting recalls, then the admin part of the equation is making sure the list is comprehensive.

Practice follow up protocols should be clearly documented and made available to all GPs. If a new or locum GP starts, don't let them invent or guess systems, tell them the way your practice does things.
A simple flow-chart detailing the follow-up choices and what actions will be undertaken for each one should be provided. You will find people respond to clear direction!

The address books in the clinical software should be maintained with correct information, especially with regard to providers who are happy to accept electronic referral. An increasing number of GPs want to communicate this way and the pay-off for the front desk will be less "fax this" requests. In the MD address book you may want to include a "*" after the specialist surname, to flag to GPs at the time of selection that they can be referred to electronically.

Teamwork can be facilitated by practice-wide meetings where staff from all sections can detail the things that are making their jobs both harder and easier. Sometimes the knowledge of the specific consequences of an action/lack of action on a teammates workload can be all that is needed to stimulate change.

eReferral

Please note the following ereferral changes for your address books:

♦ Dr Brent Mitchell	Gastroenterology	*bmitchel*	(Nth/NW)
♦ Mr Russell Furzer	Orthopaedics	russellf	(Nth/NW)
♦ Dr Umair Hyat	Cardiology	*lmc32lmc*	(Nth/NW)
♦ Ms Susan Crave	Psychology	*lmc32lmc*	(Nth/NW)

As always my full list can be found here.

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Templates

The following new templates were created or updated during the last month and are available here:

- Health Dynamics Statewide Referral **
- LGH Cardiology Referral

** A note from Health Dynamics.
Please update your current referral templates for sleep studies in Tasmania to the new Health Dynamics state-wide referrals as New Medicare requirements for a direct sleep study need the referral to include the STOP BANG questionnaire of 4 OR MORE and the Epworth Sleepiness Scale (ESS) of 8 OR MORE. An ESS score of up to 10 is in the normal range.
Using these templates will save patients and requesting providers time and grief.

MyHR

The rate of connection to the My Health Record system continues to roll on, with a little under five thousand pharmacies now connected to the system that now holds at least some information on around 22 and a half million Australians. Surprisingly the sky continues not to fall in.

Actually while I am mentioning pharmacies there is an interesting addition made to the collection of MyHR consumer information videos available here. The addition is actually audio of a radio interview done with a Queensland pharmacist talking about supplying medications to patients during and after the last Queensland floods, and how useful the MyHR was in supplying the correct medications to patients whose normal medical service or pharmacy was off the air (actually, under the water) at that time.

This was possible largely because in 2016 over a million people participated in an opt-out trial in North Queensland. It does actually highlight a topic that isn't talked about enough when discussing the potential benefits of the MyHR, namely it's utility in a disaster type scenario. It's fair to say that these situations come along readily enough.

I wonder if practices located in "high risk of bushfire" areas might consider the uploading of health summaries for their patients a prudent pre-emptive measure ?

During the last month one of the standard "scare stories" around the MyHR reared it's head in the press. The gist of it being that GPs may be coerced by insurance companies to supply them information sourced from the MyHR. What was great to see was that the Digital Health Agency quickly published a rebuttal to this story on their website. I don't know whether the response made it to the mainstream media, but at least there *was* a response, something that has been sadly lacking in recent times.

One last thing regarding the MyHR. Some of us over the last few years have been dealing with negative patient expectations about the MyHR around access and privacy etc. Some of these concerns being justified, others not so much. But I read in the Pulse Health IT newsletter of a recent case regarding a woman who had undergone a medical procedure and was full of praise about her care. However she did have trouble remembering certain bits of her history and when for instance she had had her 5th coronary stent inserted. She had assured the treating clinicians that her full details would be available on the MyHR and that they would be 100% correct . As it happened, this information had not been uploaded to the MyHR and she was a little dismayed.

There may have been very good reasons why a shared health summary hadn't been uploaded for this patient, but the point is, some people who have embraced the MyHR are going to have expectations that their key details are there. This is a level of expectation that is only going to grow. I spoke to someone the other day who had logged in to their MyHR through MyGov, and was a little surprised to see what information wasn't there. Again possibly for good reason, but people's expectations are changing, and practices that consider themselves patient-centric may want to start thinking about this shift in expectation.

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MD

A word about templates. I've created hundreds of these over the years, and generally speaking whenever myself or someone at a Primary Health type organisation creates a template, the aim is for it to be as easy as possible for the clinician to complete the document. This is largely achieved by ensuring that the document pre-populates whatever is possible from the patient record.

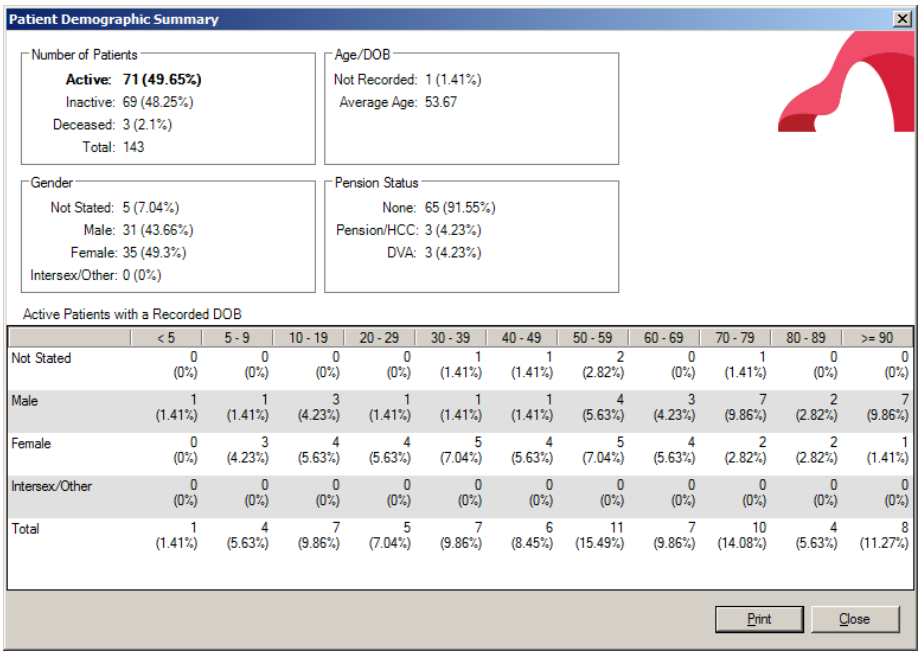
Sometimes this is tricky though. For example over the years I have weighed up whether to pre-populate a patient's ATSI status or to get the clinician to complete it manually, knowing that historically at least some practices haven't been perfect at recording ATSI status. The best compromise is making it pre-populate but also trusting that it will stand out on the form if that information hasn't been completed. The hardest one's I can think of are paediatric type referrals where the key details are obviously for the child, but the contact details need to be the parent's or guardians. Factor in the possibility of separated parents and things could get tricky. Similar issues can arise when a referral needs the details of an emergency contact or carer.

I generally deal with the issue by either asking the clinician to complete the details manually or by pre-populating on what I think the majority scenario is likely to be. The whole point of this article is to remind GPs or nurses to check their finished documents carefully, especially when reference to a party other than the patient is required. I apologise if this reminder is totally un-necessary but it is easy to get carried away by auto-populating templates and assume that they are covering everything perfectly.

MyHR Glitch - I helped a practice recently that was reporting that certain Shared Health Summaries wouldn't upload. There was no error message, but nothing actually happened when clicking on the upload icon. It turns out that if you have an item in the Past history with no date next to it, the document gets stuck. It may also happen apparently if the patient has a medical condition that is dated equal to their date of birth. Fix the date and the document will then be able to be uploaded.

Front Screen Utilities - I'm feeling "toey" about the fact that I'm 4 pages into my newsletter and there have been no graphics to break up my possibly droning text. So here are a couple of utilities available from the front screen in MD, that you might have missed.

From the *Patient* Menu, select *Demographic Summary.* You will get a breakup of your database by age and gender, as well as the number of deactivated patients. You will also get a percentage breakup of pensioners and DVA patients.



	< 5	5 - 9	10 - 19	20 - 29	30 - 39	40 - 49	50 - 59	60 - 69	70 - 79	80 - 89	>= 90
Not Stated	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (1.41%)	1 (1.41%)	2 (2.82%)	0 (0%)	1 (1.41%)	0 (0%)	0 (0%)
Male	1 (1.41%)	1 (1.41%)	3 (4.23%)	1 (1.41%)	1 (1.41%)	1 (1.41%)	4 (5.63%)	3 (4.23%)	7 (9.86%)	2 (2.82%)	7 (9.86%)
Female	0 (0%)	3 (4.23%)	4 (5.63%)	4 (5.63%)	5 (7.04%)	4 (5.63%)	5 (7.04%)	4 (5.63%)	2 (2.82%)	2 (2.82%)	1 (1.41%)
Intersex/Other	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
Total	1 (1.41%)	4 (5.63%)	7 (9.86%)	5 (7.04%)	7 (9.86%)	6 (8.45%)	11 (15.49%)	7 (9.86%)	10 (14.08%)	4 (5.63%)	8 (11.27%)

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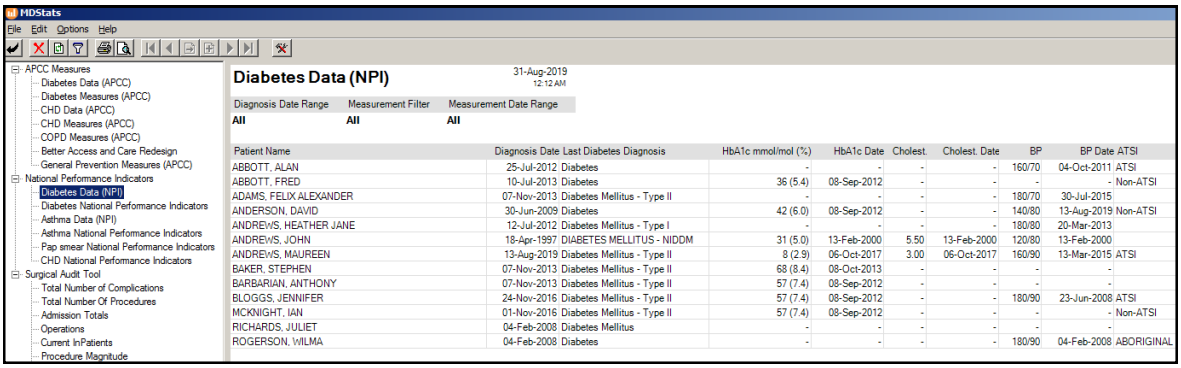
MD

Front Screen Utilities *continued..*

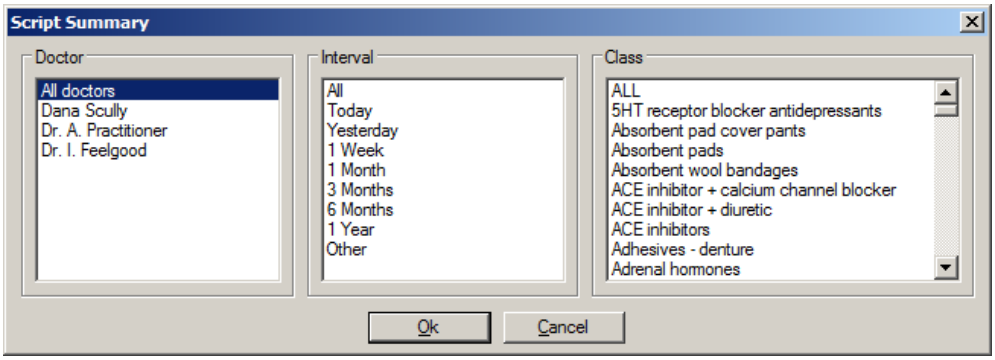
From the *File* menu, choose *MDStats.*



This will never be a replacement for PenCat or even MD's normal database searching. It has data on some of the standard APCC type measures, and deals mainly with Asthma, COPD and Diabetes, as well as a focus on ATSI patients. It may sometimes suffice for certain numbers you may need quickly.

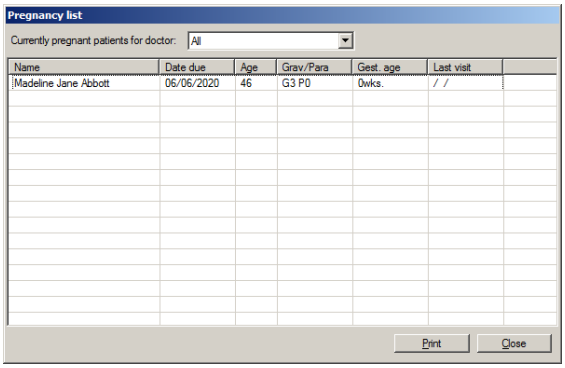
It does have one significant point of difference though, as it actually lists date of diagnosis (or at least entry into the history) for the conditions mentioned above. I am not aware of being able to extract diagnosis date in any other way, so bear this in mind if you are participating in a study that needs this. These stats are different also from the standard and PenCat searches in that they include patients who have been designated as *Visiting* or *Next of Kin* in Pracsoft. This isn't particularly helpful, and I only mention it to help explain any discrepancies you notice between this and your other figures.

From the *Clinical* menu choose *Prescription..Summary*



Here you can get a sense of an individual GP's prescribing habits, or the numbers for the whole practice.

Lastly from the *Search* menu, choose *Pregnancy list* to see how much your practice patients are contributing to the 380,000 odd babies that are born on this planet every day. So yes, coal is the problem ! ☺



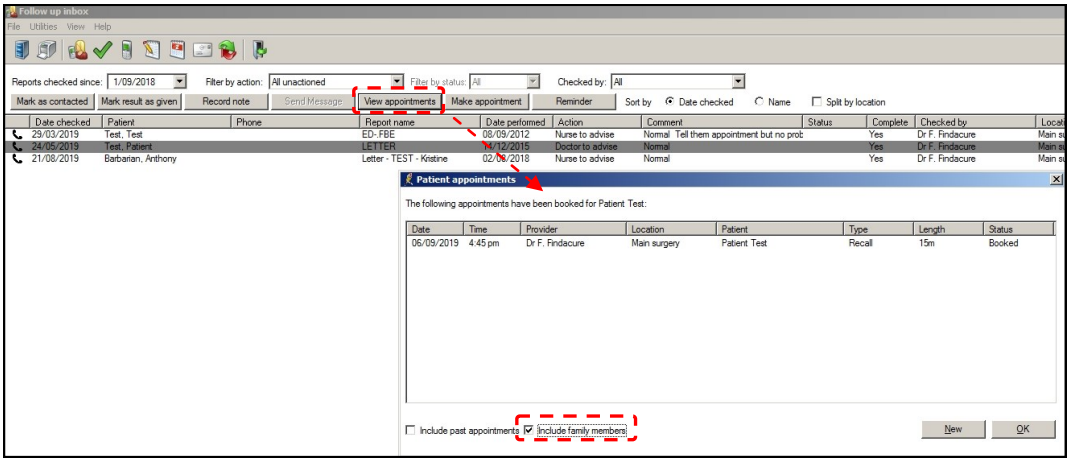
BP

There is a fair bit happening behind the scenes with the Jade release of Best Practice which was made available in mid-July. They are further formalising the configuration settings around 3rd party programs that need to read from or write to the BP database. Additionally the Better Health App which will provide an alternative to SMS messaging has been released to certain practices for testing, and integration with the Commbank Health Claim - Whitecoat system is also in a pilot or testing phase for certain practices.

There aren't many changes to the clinical side of things, but what there is is certainly worth knowing about:

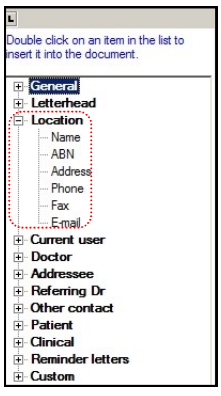
1) **Follow-Up Inbox - View Existing appointments**. There has always been the ability to book appointments from the follow-up Inbox, but as far as existing patient's appointments go, all BP could do was tell you after you had booked an appointment whether the patient had an existing one, a few days either side of the date you picked. So realistically, you would need to go to another screen to see what future appointments the patient had booked.

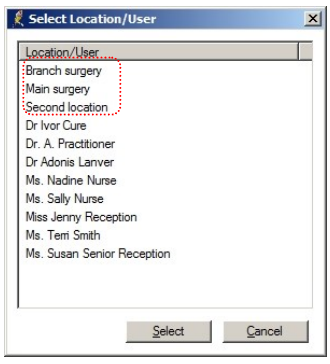
Now you have a *View Appointments* button which tells you immediately any future appointments for that patient or a linked family member.



This will make the pathology follow-up activities even easier. A bit of a bug exists though, in that if you make an appointment from this dialogue using the *New* button, the appointment type does not default to *Recall* like it does if you go straight to the *Make Appointment* button. I would expect this to be fixed in the new release.

2) **Location specific Letterheads and fields** Of much interest to multi-branch practices is the fact that you can now create Location specific letterheads. Previously you could only create a practice letterhead or a user letterhead.





Note now that you have location specific fields available for your templates including address and ABN

Continued..

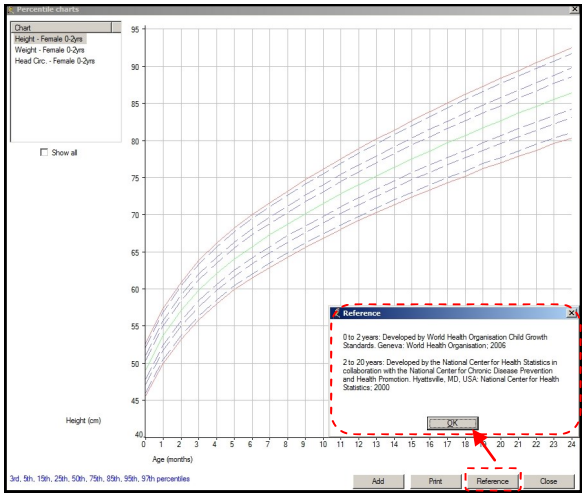
BP

Jade release continued..

I have to say that in my experience, not all practices have got their head around how practice letter-head templates work. Certainly if you have a multi-branch practice sharing the same database, these changes should make you happy.

3) **BMI Calculation for 2-20 year olds**. There is now a facility to calculate BMI for patients 2 to 20 years old. There is also a bigger percentile window for patients 0-24 months.

There is also now a reference button detailing the calculation algorithms used.



4) **Third Party Configuration** - If any of your 3rd party software programs stop working all of a sudden, check the *Setup third party integrations* button under *Setup..Configuration..Database* from the main screen. If nothing stops working then you have no need to go there.

5) **SubpoenaTool** - Now generates an entry in the patient's progress notes when it is used.

6) **Contact Notes** - Screen now shows that patient's age and date of birth.

7) **Audit C** - questionnaire now uses Australian measurements.

8) **Asthma Action Plan** - has a couple of minor changes with regard to flow measurements.

9) **My Health Record** - An overnight service now checks whether patient's that have a health Identifier downloaded have had a change of status with their MyHR, i.e. have opted out. If they have, the colour around the button in the patient record will turn to red.

10) **Inherit Sessions** - When a new GP starts, you now have an *Inherit Sessions* button which allows you to copy either the standard practice sessions, or the sessions from another GP at the practice.

11) **First Visit date** - For Practices that host Specialists there is now a facility to enter date of first visit when you create an account, enabling better calculation of referral expiries.

Note: Checking Templates. I wrote the full sub-text of this in the MD article at the top of page 4, feel free to read it. If not, the executive summary is to check a completed document carefully after you have created it. This is especially important where the document makes reference to a 3rd party like a parent or carer or emergency contact. Template creators (like me) try to pre-populate as much as we can, but it is possible to miss the mark as far as for example, parent details go, especially in the case of divorced or separated parents.