PracSavvy

Clinical Systems Support and Training

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September 2020 — Newsbrief

This month, from a technology in health perspective, we have some good news with a long awaited system improvement, and some frustration with the *sprint..walk..stop..walk* progress of another one.

The good news is that the THS clinical teams now have access to the MyHR. I have written before how disappointing it has been that Tasmanian public health clinicians were the only ones in the country not to have this access, but happily I can carp about this no more. My hope is that along with it's introduction, there is training in the use of MyHR and awareness of the information it can yield. We all know that introduction of new computer software is not always accompanied by effective and informed training.

But don't let my cautious optimism dilute the fact that in our state at least public DEM doctors *especially* are the very group that the whole MyHR system was designed to assist. This is a big change, and something to be celebrated. I'm also looking forward to getting something other than a blank look when I mention the concept to the next group of registrars or interns that I meet. Finally, if you have some doctors who aren't interested in *Shared Health Summary* creation because 'the Royal can't even view the system', feel free to update them.

On another note, for a couple of months I've been itching to write a de-scriptive article on e-scripts. (See what I did there!) An e-script being a scannable code that's sent to a mobile phone or an email account instead of printing out a paper script. It's an option for prescribing that I'm absolutely sure GPs are going to love, and not just the ones that work via "tele".

But the roll-out has been less then plain sailing. Below is a rough sequence of events as I perceive them, it may not be 100% accurate in detail but it's pretty close and certainly close enough for a publication with a readership of around 6.

- Around February/March, as a reaction to the Covid pandemic the Australian Digital Health Agency urged clinical software companies to fast-track the addition of e-script functionality to their products.
- Around the same time the Department of Health announced that they would fund the delivery of SMS scripts until September 30th at least.
- In late June/July Queensland and South Australia passed minor law amendments to bring themselves in line with other states and make e-scripts legal prescriptions.
- July 27th Best Practice (BP) released Jade Service Pack 3 together with a utility to download and run in order to turn e-scripts on. (as long as you were using ERX as your eprescribing provider)
- Another clinical program Zedmed released an e-scripts update to it's product.
- A few BP practices installed the Service pack, ran the utility and started using e-scripts
- Whilst some pharmacies could happily process the scripts, many others hadn't updated their dispensing software and couldn't or at least *thought* they couldn't fill the scripts. Some of these pharmacies started to feel the heat of customer dissatisfaction, and they weren't happy.
- I always thought only Assassins and Thieves had *guilds*, but apparently pharmacists do too. Their guild lobbied the ADHA to great effect. They raised the point that a government education program for consumers might have been a good idea, and they may have had something there, (remember the MyHR). On the other hand, the Department of Health may contest that they had other priorities to deal with in these Covid times. Either way, I guess 2 consecutive experiences have taught us that we can't rely on private health sector workers to provide consumer education on national health initiatives if there isn't a dollar in it for them!
- Within a couple of weeks of BP releasing their e-scripts utility they were asked to withdraw it. Practices that had already run the enabling utility were allowed to keep e-prescribing as it's now a perfectly legal form of script. If they were fortunate to be working with nearby pharmacies who were compatible, then there was no reason to stop, and I'm pretty sure none of them did.

Read Over...

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- Around August 17th, BP made it's e-script utility available again, as long as the practice Post Code was in an area that is considered a Community of Interest (COI). These COI's were basically areas containing pharmacies that had tested e-scripts and were happy to accept them. These pharmacies were mostly involved in the initial testing, but also some were ones that had registered themselves as a COI after upgrading their software.
- A few days later the areas of Melbourne effected by the COVID-19 second wave were added to the COI list.

So that's where we are at. It does raise some questions though. I guess the biggest one being, how did it happen that despite government funding announcements, state legislation changes and frantic BETA testing of Australia's clinical prescribing programs, somehow the urgency of the whole thing didn't filter down to the pharmacy sector as a whole. I actually think that there are plenty of pharmacies that think they are in-compatible, but actually can process the scripts, more of that later in this edition.

I've seen some good examples on social media (*seriously never thought I'd write that sentence*) of practices on the mainland taking progress into their own hands. They have talked to nearby pharmacies to ensure that they are both compatible and happy, and are loving doing e-scripts. To do this, they would have either, downloaded the enabling utility before it was withdrawn, been lucky enough to be located in a COI or along with their local pharmacies, registered themselves as a COI.

So in Tasmania, if you use BP and ERX, you can try and download the utility via their web page. It will only give you the file if your postcode is in a COI. As at the time of writing, these are the Post Codes that will give you access to the file.

7248,7249,7250,7252,7254,7258,7259,7260,7262,7267,7268,7301,7306,7307,7310,7315,7316,7321.

If your practice is not in one of these Post codes, you may want to talk to your local pharmacies and possibly register yourselves as a COI. I don't know how efficient the process is but you can start the conversation here: help@digitalhealth.gov.au

It's fair to point out that this version of e-scripts is only an interim version of what is finally intended, and it's possible that the belated fast-track version might merge into the next iteration very quickly, rendering my article over the page, quickly redundant. But I wanted to write about how it's supposed to work now. As mentioned in the last issue there is also a good online CPD incentivised course here.

Templates

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

- Mental Health Nurse Program Referral and Consent form (South)
- Covid letter to School or Employer (Updated)
- Blood Pressure 7 Day Diary

eReferral

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

Traci Lonergan	Nurse Practitioner/Diabetes Educator			*tldiabet (North)*
Dr Srija Bhattacharrya	Cardiologist	*heartctr*	*Delete*	*(North)*
Dr Emily Kotschet	Cardiologist	*heartctr*	*Delete*	*(North)*

Traci Lonergan is a Nurse Practitioner taking new referrals for people with type 1 diabetes, with a focus on technologies such as insulin pump therapy and continuous or flash glucose monitoring.

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e-scripts

I've dealt with the *what* and *where* earlier in the newsletter, so now I'll give a bit of a run through on the *how.* While this article references BP in part, the overall principles will apply to MD as well, particularly from the patient perspective.

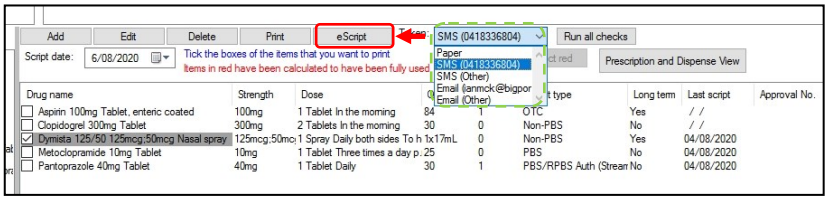
In a recap from a previous edition, these are some of the preparatory things you need to tick off.

- Enter HPI-I numbers for your Drs. If you haven't already.
- Obtain and enter the AHPRA numbers for your GPs (There isn't a field for this in MD until 3.19)
- Import Patient's HI numbers. MD looks up these numbers automatically, In BP they can be looked up individually or in bulk.

If you are running BP Java SP3, and have downloaded and run the utility and use ERX as your e-prescribing provider, then you are all ready to generate e-scripts.

Its import to note that an e-script is merely another prescribing option for GPs. It sits right alongside the normal paper based options and GPs can generate scripts in whichever format they prefer. Whilst GPs may decide whether to use an e-script on a patient by patient basis, one thing that will influence their choice is that it requires one e-script per medication. So if 5 or 6 medications are being prescribed, I imagine most GPs will use a paper based script.

It's as simple as picking the option you want and then clicking eScript.

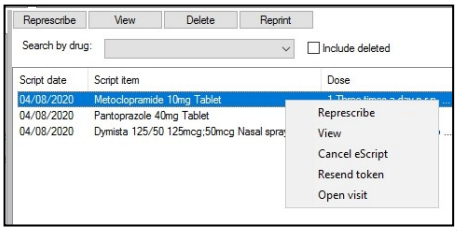


When generating an e-script the GP can choose whether to provide either:

* A printed version of the e-script
* An e-script via SMS to the patient's recorded mobile number
* An e-script via SMS to another number
* An e-script to the patient's recorded email address
* An e-script to another email address

If the patient is in the room with the GP, then it will be an easy matter to confirm that the patient has received an SMS e-script on their phone. It should also be apparent the advantages here in terms of GPs working in Telehealth situations, where they are remote to the patient. Similarly the ability to send an e-script to a carer's phone could be advantageous.

If for some reason the GP needs to cancel the e-script or resend it, it's as simple as going to *Past Prescriptions*, and right-clicking on the script. This invokes the menu depicted at right, with the functionality choices being apparent.



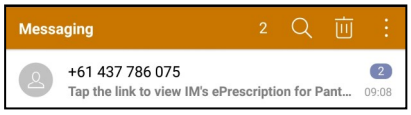
e-scripts

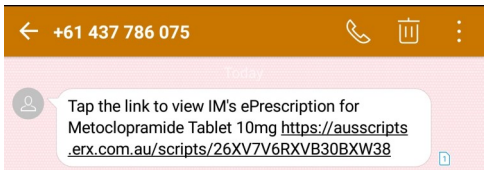
Continued...

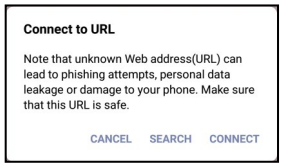
It really is as simple as that. Note that in this iteration the e-script is sent from ERX, as opposed to Best Practice. So it doesn't matter whether you have SMS or email set up in your BP. It is federally funded until September 30th at this point. Best Practice have advised that when the system evolves to the next stage and the SMS is sent from BP, the cost will be about 4c per script.

What does the Patient See ?

In this instance we will deal with the SMS delivered version, note that whichever way the e-script is delivered, the e-script (or token as you may see it called) is the same.



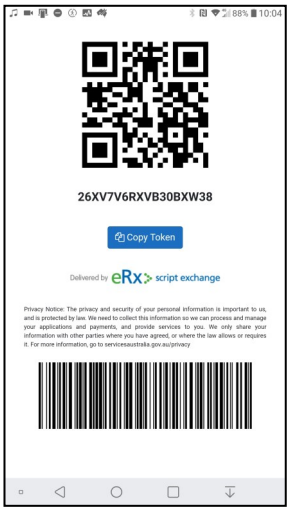




This is the sequence on my Android phone. An initial notification, the full message and the standard warning when you tap on a hyperlink. Now the good bit.

To the left you see the actual e-script token. This is what is known a a QRCode, and pharmacies need to have a scanner that can read qrcodes. Note that this qrcode is not the script, but rather a secure key to the script that is held at the Prescription Delivery Service (ERX), and subsequently downloaded to the pharmacy dispensing software.

Directly beneath the code there is a text string which can also be manually keyed into compatible dispensing software, which whilst cumbersome, is another way the script can be processed.



There is another way this e-script can be processed that I think a lot of pharmacists are unaware of, and could potentially mean that they already have the ability to process these e-scripts, (I think). If you scroll down the screen from the qrcode, another barcode is revealed, as per the graphic above right. This barcode is the same one as the one that would have appeared at the bottom of an existing paper script for this medication. Now I haven't seen this second barcode mentioned in any of the promotional/educational material, but it does make me think that if a pharmacy was happily scanning barcodes off paper scripts previously, then they should be able to scan the barcode from this e-script.

So there it is in a nutshell. If there are repeats involved the pharmacy will send the e-script/token to the patient when appropriate. There is much good further information here:

ADHA Best Practice Videos ERX

If you are keen and want things to move quickly, approach your local pharmacies and find out if they are e-script enabled. If they are, then get your area registered as a Community Of Interest (if they aren't already) by emailing the Aus Digital Health Agency here, so that BP will give you access to the utility, as well as speeding up uptake generally.

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Rosny Doctors & Afterhours clinic are relocating from Monday 7th September.
New Address: 27 Bligh Street, Rosny Park
Contact details and Healthlink EDI are unchanged.

PenCat TopBar

Some bits and pieces from PenCS over the last few weeks. One of the more notable things from my perspective, is that for the first time that I'm aware of, they have released pricing information for their products should practices not be able to access the PHN funded licences. This means that if Primary Health Tasmania opts not to renew their state wide licence for PenCat and TopBar, (unlikely as they always make great decisions) practices will be able to pay for licences to these programs.

There is however one scenario, that may appeal to certain practices right now. The PIPQI incentive is available to practices if they a) Send de-identified PenCat data to PHT and b) Can demonstrate some sort of Quality Improvement Exercise using a PDSA cycle. I am aware of at least 1 practice that doesn't qualify for QPIP because they are uneasy about sending their entire PenCAT extract to PHT, even if it is de-identified. One of the priced offerings from PenCS is called *PIP Eligible Data Set Submission* and it will cost you $1188.00 per annum. This gets you PenCat, TopBar and the ability to manually upload to PHN a reduced deidentified data set that only includes the ten specific Department of Health measures, as opposed to the full deidentified data set that is generated and shared via the PenCS scheduler.

Depending on how the numbers stack up, this may be a way for more practices to access the PIPQI payments.

The latest version of PenCat is 4.26.1.1, and there have been some minor improvements and fixes over the last few weeks. Namely;

- The Gender filter and Demographic report titles have been modified to differentiate between gender not recorded/unknown and non-binary.
- The Age Profile (RACGP) report has been modified along the same lines.
- The *Diabetes Sip Items-Items completed per patient* report that I mentioned being broken in the last newsletter has now been fixed.
- More Covid-19 PCR test names have been added to the mapping, so practices should be able to see lists of who has had a test. (Mentioned in July PracSavvy)
- The PenCS scheduler has been updated so that multi-location practices can send off branch specific extracts.
- New Diagnosis added to Heart Failure mapping for BP users
- Added a checkbox to the extracts pane to enable hiding de-identified extracts.

The latest release of TopBar is version 2.10, but they seem to push the updates out gradually. If you navigate to your *Settings* menu, and select *About TopBar*, you will be able to see what version you are running. They have updated a couple of things recently:

- Fixed issue with Waiting Room App not showing some patients
- Fixed Smoking status issue in PIP QI app for MD users
- Now picking up the "Opt-Out" option for Cervical Screening in the PIP QI app.
- Added appropriate Item Numbers for Non-VR GPs in the MBS app.

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