Train IT Medical
Leading Your Practice Into The Digital Future

phn NORTHERN SYDNEY
An Australian Government Initiative

SYDNEY NORTH Health Network

Digital Health in Practice

MedicalDirector

Bp Premier

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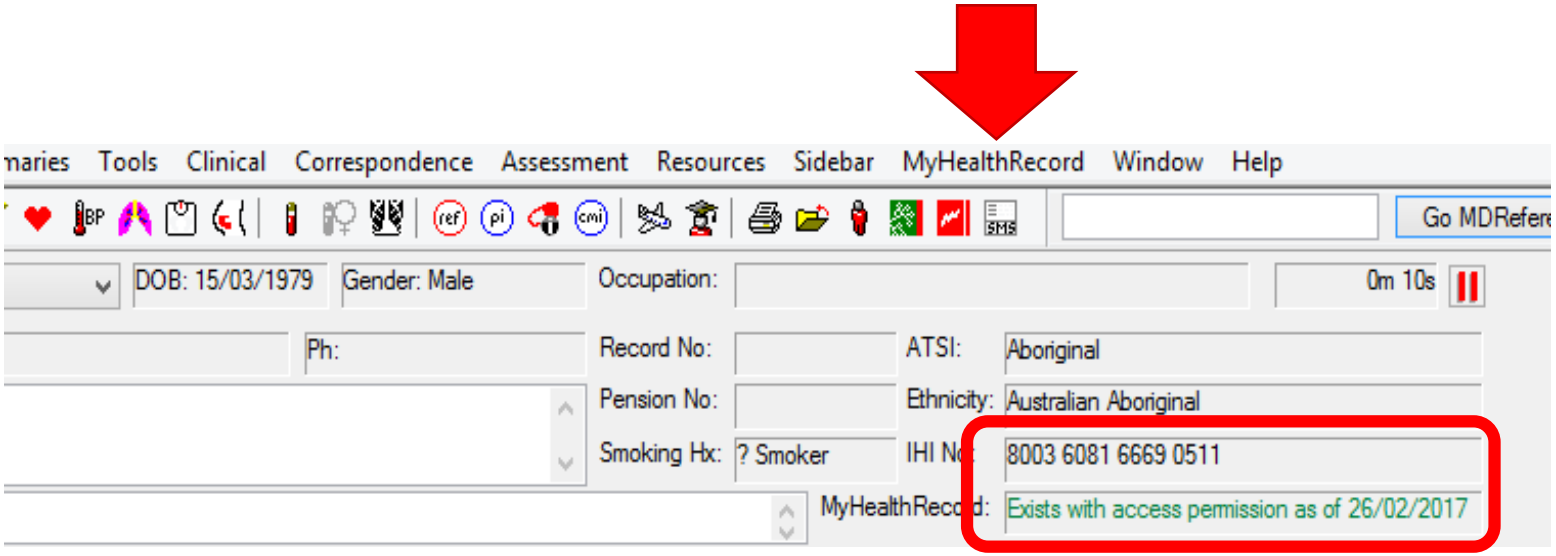
Learning Objectives:

- Access a patient's My Health Record and upload a Shared Health Summary and Event Summary
- Develop a plan for your own practice data to meet safety, accreditation and practice incentive requirements
- Access and utilise reports related to My Health Record and quality improvements

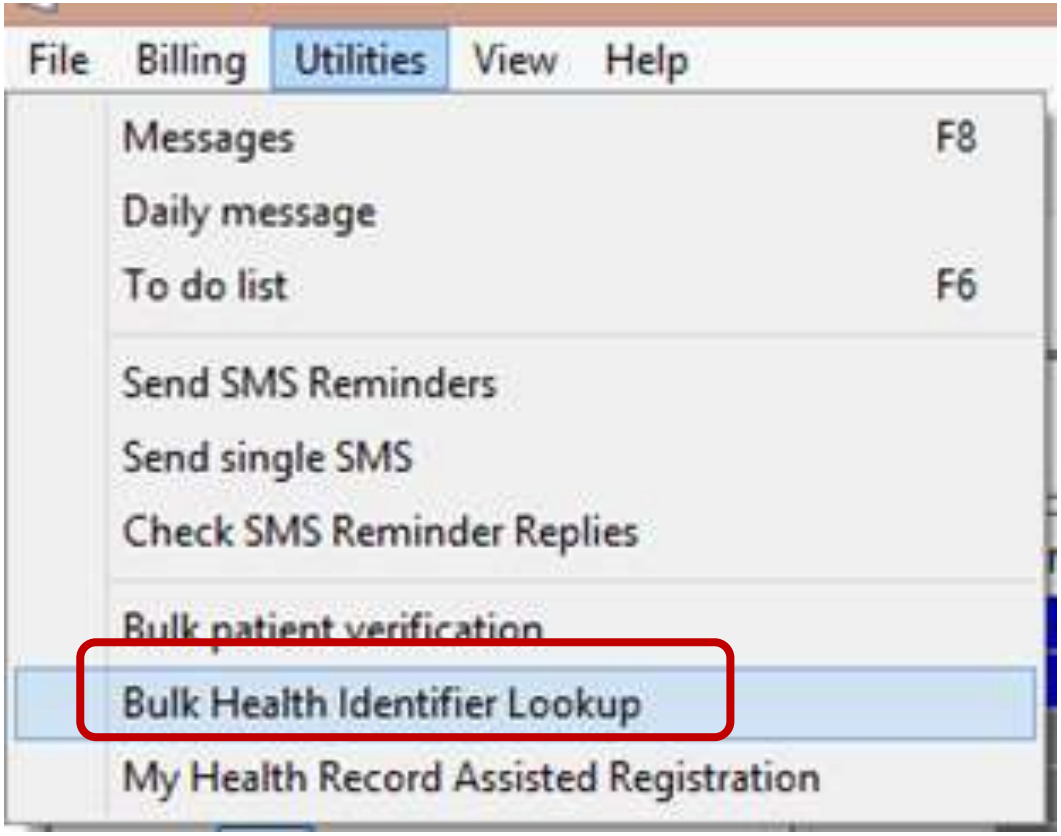
IHI Validation

My Health Record

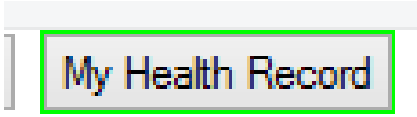
MD checks automatically if patient has an IHI and My Health Record



IHI Validation - Bulk



Will put green box if patient has a My Health Record



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Practise in the ‘On Demand’ test environment

See what
My Health Record
looks like from a
consumer
perspective.

Go to On Demand Training Environnment

View your patient's My Health Record

MedicalDirector

naries Tools Clinical Correspondence Assessment Resources Sidebar MyHealthRecord Window Help

Go MDRefere

DOB: 15/03/1979 | Gender: Male | Occupation: | 0m 10s

Ph: | Record No: | ATSI: Aboriginal

Pension No: | Ethnicity: Australian Aboriginal

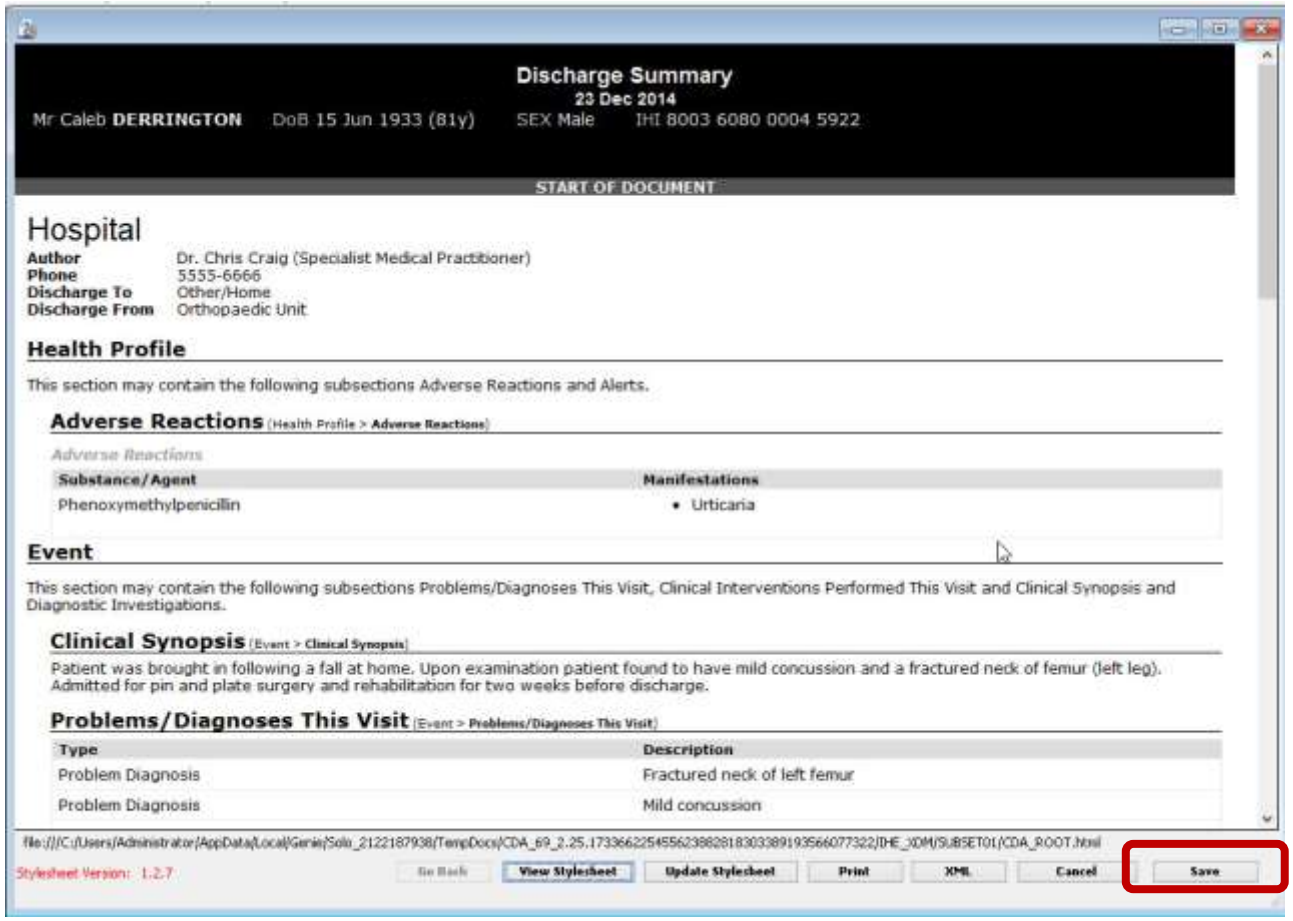
Smoking Hx: ? Smoker | IHI No: 8003 6081 6669 0511

MyHealthRecord: Exists with access permission as of 26/02/2017

- **Exists requires access code as of DD/MM/YYYY:** The patient has a My Health Record record but it requires an access code. The patient has setup the access code for his/her My Health Record.
- **Exists with access permission as of DD/MM/YYYY:** The patient has a My Health Record record and you may access the patient's My Health Record.
- **Does not exist or not disclosed as of DD/MM/YYYY:** The patient either does not have a My Health Record or the My Health Record record is hidden.
- **IHI not recorded as of DD/MM/YYYY:** The patient does not have an IHI recorded.

Access information

eg Discharge Summary or Health Summary



Discharge Summary
23 Dec 2014

Mr Caleb **DERRINGTON** DoB 15 Jun 1933 (81y) SEX Male IHI 8003 6080 0004 5922

START OF DOCUMENT

Hospital

Author Dr. Chris Craig (Specialist Medical Practitioner)
Phone 5555-6666
Discharge To Other/Home
Discharge From Orthopaedic Unit

Health Profile

This section may contain the following subsections Adverse Reactions and Alerts.

Adverse Reactions (Health Profile > Adverse Reactions)

Adverse Reactions

Substance/Agent	Manifestations
Phenoxymethylpenicillin	• Urticaria

Event

This section may contain the following subsections Problems/Diagnoses This Visit, Clinical Interventions Performed This Visit and Clinical Synopsis and Diagnostic Investigations.

Clinical Synopsis (Event > Clinical Synopsis)

Patient was brought in following a fall at home. Upon examination patient found to have mild concussion and a fractured neck of femur (left leg). Admitted for pin and plate surgery and rehabilitation for two weeks before discharge.

Problems/Diagnoses This Visit (Event > Problems/Diagnoses This Visit)

Type	Description
Problem Diagnosis	Fractured neck of left femur
Problem Diagnosis	Mild concussion

Stylesheet Version: 1.2.7 | Go Back | View Stylesheet | Update Stylesheet | Print | XML | Cancel | Save

Examples for Event Summary use:

- Patient receiving care at an After Hours Medical Service
- A patient receiving travel vaccinations or a flu vaccine
- A physiotherapy or occupational therapy appointment with information that would benefit other members of the care team.
- Travelling / transient patients / grey nomads
- Visit to any psychologist or a dietician – starting or finishing treatment.

Privacy Controls and Patient View

My Health Record

BRIANNA CURTIN
Born 20-May-1998

RECORD HOME | DOCUMENTS | PRIVACY & ACCESS | PROFILE & SETTINGS | SEARCH | HELP

< Back

Clinical Records

These are documents with clinical information entered by healthcare providers in My Health Record.

Diagnostic Imaging Reports
Imaging results, such as scans and x-rays.

Discharge Summaries
Records of hospital stays and any follow up treatment required.

e-Referrals
Referrals from one treating healthcare provider to another.

Event Summaries
Information about healthcare events or consultations.

Pathology Reports
Test results, such as blood tests.

Shared Health Summaries
Summaries of your health status added by healthcare providers.

My Health Record – Medicines Preview

Available medicines in this My Health Record - sorted by Date
22 Nov 2017

Caleb **DERRINGTON** DoB 15 Jun 1933 (84y) SEX Male IHI 8003 6080 0004 5922

Allergies and Adverse Reactions **Penicillin, Penicillins**	**Medicines Preview** 22-Nov-2017 (now)	**Shared Health Summary** 22-Nov-2017 (now) **Author:** Dr Terrance Walker Own Organisation tel:04555555555	**No Discharge Summary found**

[Back to top] [<<] First [<<] Previous [Help]

Medicines Preview - Latest Documents - sorted by descending event date.
22-Nov-2017 (now)

Source/Author	Date	Medicine - Active Ingredient(s)	Medicine - Brand	Directions
Event Summary by Own Organisation	22-Nov-2017 (now) changed		Monodur 120mg Tablet	1 Tablet Daily for 0
Shared Health Summary by Own Organisation	22-Nov-2017 (now)		Actonel EC 35mg Tablet	1 Tablet Once a week for 0
			Avanza 30mg Tablet	1 Tablet Before bed for 0
			Avapro HCT 300/12.5 300mg;12.5mg Tablet	1 Tablet Daily for 0
			Crestor 20mg Tablet	1 Tablet Daily for 0
			Madopar 200mg;50mg Tablet	1 Tablet Three times a day for 0
			Monodur 120mg Tablet	1 Tablet Daily for 0

Navigation panel

Provides access to each section within the view and also to the most recent Shared Health Summary and Discharge Summary (if available).

The blue underlined hyperlinks can be used to navigate between the sections

Pathology and Diagnostic Imaging included

My Health Record Document List - Mr Caleb Derrington

DocumentType: All

☐ Show last 3 months only

Update

☑ Exclude Medicare documents ☑ Exclude prescription and dispense records ☑ Exclude superseded or removed documents

Reset

Current filter: Excluding Medicare documents; Excluding prescription and dispense records; Excluding superseded or removed records

Document Date	Service Date	Document	Organisation	Organisation Type
22/11/2017		Medicines View		Local Government Healthcare Administration
22/11/2017		Event Summary	Medical Center	Local Government Healthcare Administration
22/11/2017		Shared Health Summary	Medical Center	Local Government Healthcare Administration
03/04/2017		Shared Health Summary	Medical Center	General Practice
03/04/2017		e-Referral	Medical Center	General Practice
03/04/2017		Specialist Letter	Medical Center	General Practice
03/04/2017		Discharge Summary	Medical Center	General Practice
27/03/2017		Pathology Report	Sullivan Nicolaides Pathology	Pathology and Diagnostic Imaging Services
27/03/2017		Diagnostic Imaging Report	Imaging Queensland	Pathology and Diagnostic Imaging Services
17/03/2017		Diagnostic Imaging Report	Wesley Medical Imaging	Pathology and Diagnostic Imaging Services
17/03/2017		Pathology Report	Mater Pathology	Pathology and Diagnostic Imaging Services
10/03/2017		Pathology Report	Pathology Queensland	Pathology and Diagnostic Imaging Services
10/03/2017		Diagnostic Imaging Report	Brisbane Diagnostics	Pathology and Diagnostic Imaging Services
01/03/2017		Diagnostic Imaging Report	Queensland Diagnostic Imaging	Pathology and Diagnostic Imaging Services
01/03/2017		Pathology Report	QML Pathology	Pathology and Diagnostic Imaging Services

Superseded Removed

Open Save History Supersede Access Code Close

Prepare for patients seeing their own results

Now might be a good time to start to explain to your patients:

- doctors will still receive results first. Detail your practice process for follow-up.
- just because a result is marked red/‘abnormal’/outside the value range doesn’t mean the result is not normal for them.
- just because a result is marked ‘normal’ doesn’t mean further discussion or investigations are not necessary.
- patients can let the doctor know if they do not want a specific result uploaded to their My Health Record.

▶ D. Our practice team can describe how patients are advised of the process for the follow up of results.

▶ E. Our practice team can describe how we follow up and recall patients with clinically significant tests and results.

www.racgp.org.au

Factsheet: Pathology Reports for Clinicians

Quality patient information

Lab Tests Online AU
EXPLAINING PATHOLOGY

https://www.labtestsonline.org.au

Inside Radiology

https://www.insideradiology.com.au/

Apps that connect to My Health Record:

HealthEngine
HealthEngine Pty Ltd
More information about HealthEngine

Healthi
Chamonix Health Solutions Pty Ltd
More information about Healthi

HealthNow
HealthNow
More information about HealthNow

My Child's eHealth Record
The Australian Digital Health Agency
More information about My Child's eHealth Record

Tyde
Tyde Australia Pty Ltd
More information about Tyde

https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/appconnect

Learning Objectives:

- Develop a plan for your own practice data to meet safety, accreditation and practice incentive requirements

"..use consistent **coding** of diagnoses.....so that continuous improvement of clinical care and patient outcomes can be achieved."

Past History List [coding]

Past History

Date: / / 2013 9/12/2017

Condition: Total knee replacement

Keyword search | Synonyms

Condition
- Total knee replacement
- Total knee replacement revision

☑ Left ☐ Right ☐ Bilateral
☐ Acute ☐ Chronic
☐ Mild ☐ Moderate ☐ Severe
☐ Active ☑ Inactive
☐ Provisional diagnosis

Fracture:
☐ Displaced ☐ Undisplaced
☐ Compound ☐ Comminuted
☐ Spiral ☐ Greenstick

Further detail:

Dr Mary Smith - St George Hospital

☑ Send to My Health Record
☐ Confidential
☑ Include in summaries

Save | Cancel

- Only for chronic conditions & significant events
- Significant active or inactive conditions
- Add detail

Australian Government
Australian Digital Health Agency

My Health Record

Data Quality Checklist for all 'active' patients

1. **Demographics – are the contact details up-to-date?** ☐
   - Double-click on the patient's telephone number to check and update details
2. **Medication List – is the Current Meds list accurate?** ☐
   - Right click to delete/cease medications no longer relevant (they can then be found in the Old/Past Scripts thereafter)
   - If none, tick No medications
3. **Past History List – does it contain only significant conditions that a hospital or specialist would need to know?** ☐
   - Right click to edit, delete or add new
   - If none, tick No significant past history (PMH) box
4. **Allergies – have you also recorded adverse reactions?** ☐
   - Double-click in allergies box and Add, Edit, Delete
   - If none, tick No Known Allergies/Adverse Reactions/Nil Known
5. **Immunisations – have immunisations been recorded?** ☐

www.myhealthrecord.gov.au www.digitalhealth.gov.au

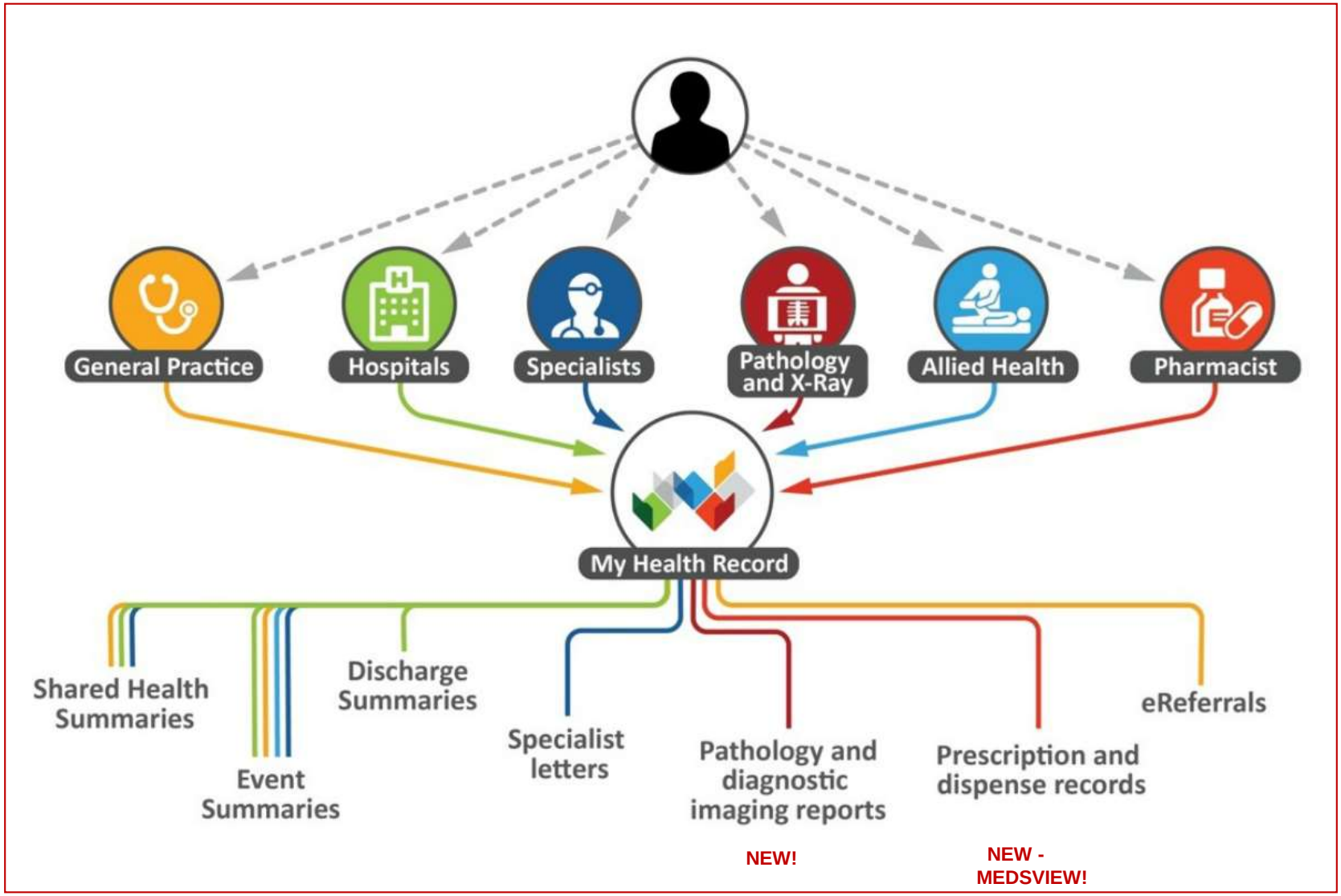
Download the 'Data Quality' Checklist

– GP Consultation Checklist

Workflow & Minimum Clinician Data Entry

- Review previous consultation notes ☐
- Review or collect history ☐
- Current Medications ☐
- Recent side effects/allergies ☐
- Check Result/Documents and MARK AS NOTIFIED ☐
- Examination & Management ☐
  (enter all observations BP, pulse etc in correct fields)
- Findings/Diagnosis ☐
- Patient Education ☐
- Add/Remove Recall or make next appointment ☐
- Reason for contact ☐
- MBS item/voucher ☐

Final step – do I need to update SHS and send to My Health Record?



www.digitalhealth.gov.au

www.myhealthrecord.gov.au

Accreditation: Quality Improvement (QI) Module

Criterion QI1.1 – Quality improvement activities

Indicators

QI1.1►A Our practice has at least one team member who has the primary responsibility for leading our quality improvement systems and processes.

QI1.1►B Our practice team internally shares information about quality improvement and patient safety.

QI1.1►C Our practice seeks feedback from the team about our quality improvement systems and the performance of these systems.

QI1.1►D Our practice team can describe areas of our practice that we have improved in the past three years.

https://www.racgp.org.au/download/Documents/Standards/5th%20Edition/racgp-standards-for-general-practices-5th-edition.pdf

Data Improvements

- ✓ Aboriginal and Torres Strait Islander health
- ✓ Smoking status
- ✓ Alcohol
- ✓ BMI
- ✓ Blood Pressure
- ✓ Kidney function test recorded
- ✓ Diabetes
  - HbA1C
- ✓ - ACR
- ✓ Cardiovascular Disease
- ✓ Chronic Kidney Disease
  - eGFR
- ✓ GPMP and TCAs
- ✓ Cervical Screening

Create an Improvement Culture

Example of coding improvement activity:

- Generate Data Quality Dashboard in data extraction tool e.g. POLAR for individual providers (evidence based approach showing real data rather than assumption).

- Create QI/PDSA to support Quality Improvement Activity (and prepare for QIPIP)

Allergies and adverse reactions		89.24%
Medicines		48.03%
Medical History		88.56%
Health Risk Factors		68.34%
Immunisations		64.45%
Relevant Family History		54.30%
Relevant Social History		93.52%
Non-Duplicate Patients		99.22%

MD Clinical Data Statistics

QI Activity:

QUALITY IMPROVEMENT TOOLKIT RESOURCES

phn

SYDNEY NORTH
Primary Health Network

Quality Improvement in Primary Care

Quality Improvement Action Worksheet

PLAN, DO, STUDY, ACT

Please complete a new Worksheet for each change idea you have documented on the previous page.

Where there are multiple change ideas to test, please number the corresponding worksheet(s).

Example QI Activity: Data Quality

What are we trying to accomplish? Improved data quality in health summary
How will we know that change is an improvement? % of active patients with active medications recorded will increase by 20%
What changes can we make that will lead to an improvement?
Ideas:

1. Archive inactive patients in database
2. Train staff to enter data correctly
3. Print health summary for patients and ask them to review while waiting at next visit
4. Implement consultation checklist

Example QI Activity: MyHealth Record Enablement

What are we trying to accomplish? Increased use of My Health Record
How will we know that change is an improvement? % of active patients with a Shared Health Summary uploaded will increase
What changes can we make that will lead to an improvement?
Ideas:

1. Enter HPI-I numbers for all clinical staff in CIS and HPOS
2. Ensure NASH and PKI certificates are current
3. Train staff to access and upload Shared Health Summaries (On Demand)
4. Verify IHI Numbers for all exceptions
5. Educate patients on My Health Record
6. Build routine workflow that includes checking My HR for information

PDSA/QI sample related to clinical coding

What is our GOAL (what are we trying to accomplish)	**Raise Awareness of Clinical Coding** ▪ Code diagnoses ▪ Enter reason for visit ▪ Enter for reason for medication ▪ Maintain updated allergy detail
What measures will we use? (i.e. data)	**Data Extradition Tools e.g. Pen CAT**
What ideas can we use? (how are we going to achieve our goal)	*List ideas here to work on in table below* Start a Quality improvement folder Team meeting Attend education e.g. webinars / face to face sessions Post-education follow-up team discussion GP & RN team review of clinical documentation (opportunistic or planned) Pen CAT / Polar Data Quality Audit

IDEAS	PLAN How will we do it – who, what, where and when?	DO Did we do it	STUDY What happened?	ACT What is our next step?
1.				
2.				
3.				
4.				
5.				

Learning Objective 3:

- Access and utilise reports related to My Health Record and quality improvements

Data Quality Dashboard – PEN CAT4

Data Quality Dashboard | Data Completeness Report | Data Completeness Patient Graph | Duplicate Number Patient Report | Duplicate

1 of 1 100% Find | Next

Data Quality Dashboard

Report Date: 12/02/2015 9:57 AM

Practice Name: Deidentified Practice

Data is taken from the Data Completeness Report and Duplicate Patients Report.

Allergies and adverse reactions		72.33 %	View Guidelines
Medicines		24.40 %	View Guidelines
Medical History		87.67 %	View Guidelines
Health Risk Factors		57.54 %	View Guidelines
Immunisations		61.59 %	View Guidelines
Relevant Family History		44.54 %	View Guidelines
Relevant Social History		73.80 %	View Guidelines
Non-Duplicate Patients		0.00 %	

Requirement 5 – SHS Uploads

Requirement 5 — My Health Record system

The practice must:

- i. Use compliant software for accessing the My Health Record system, and creating and posting shared health summaries and event summaries;
- ii. Apply to participate in the My Health Record system upon obtaining a HPI–O; and
- iii. Upload a shared health summary for a minimum of 0.5% of the practice's standardised whole patient equivalent (SWPE) count of patients per PIP payment quarter.

https://www.digitalhealth.gov.au/get-started-with-digital-health/pip-ehealth-incentive

ePIP – Calculating Shared Health Summary Uploads

2017/2018 Shared Health Summary Uploads

Quarterly payment period	SWPE for the Qtly payment period	Minimum SHS Upload target (SWPE x 0.5%)	Actual SHS Uploads for the payment period
November 2017 to 31 January 2018			
February 2018 to 30 April 2018			
May 2018 to 31 July 2018			
August 2018 to 31 October 2018			

ePIP Widget (Sidebar)

Sidebar NEW

ePIP Shared Health Summary Calculator

<< View 2015 - 2016

2016 - 2017

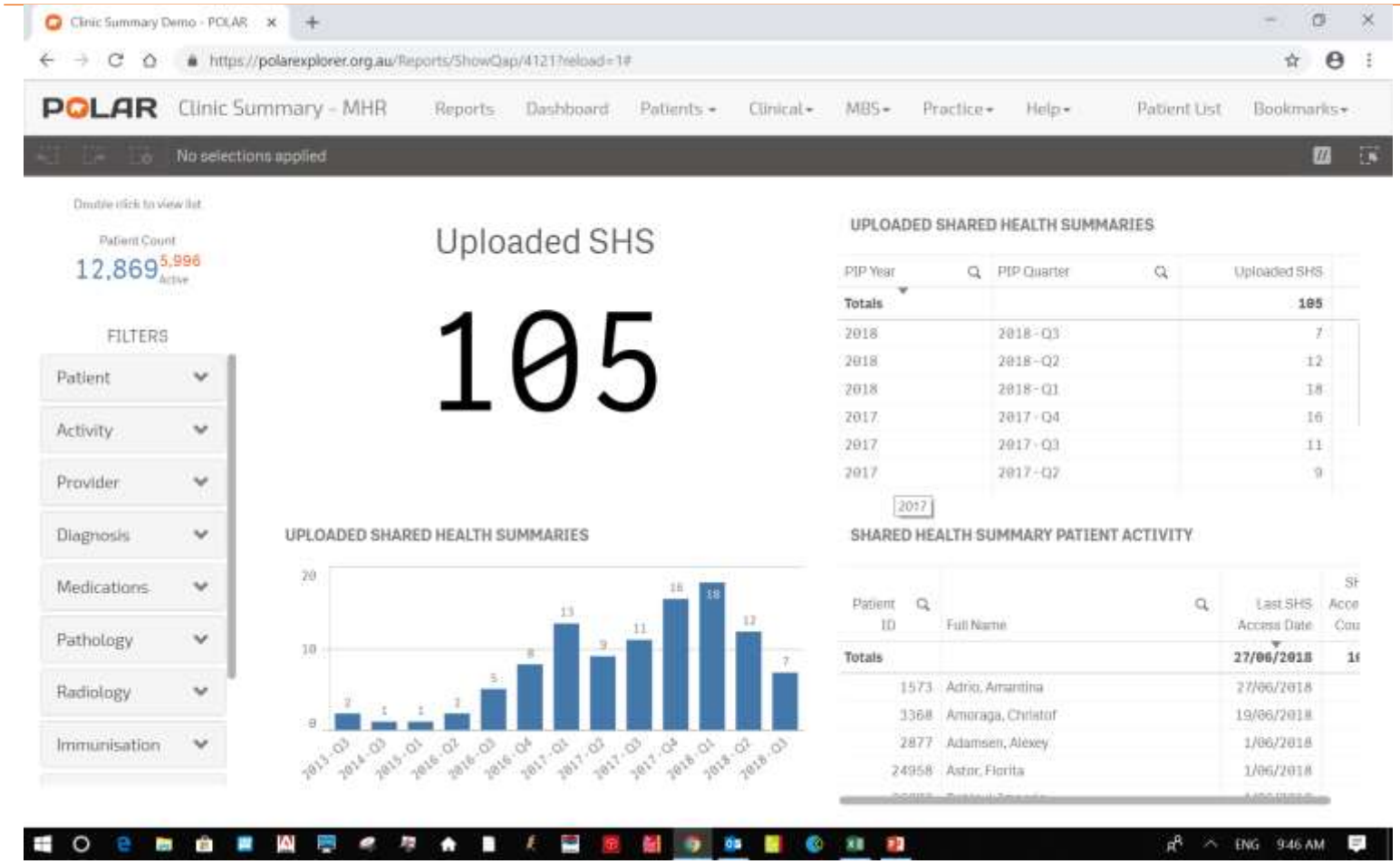
PIP Quarterly Period	SWPE[1]		SHS min. upload target[2]	SHS Practice upload
Nov to Jan 31	NOV	1000	5	0
Feb to Apr 30	FEB	1000	5	0
May to Jul 31	MAY	1000	5	0
Aug to Oct 31	AUG	1000	5	0

1. *Use the Standard Whole Patient Equivalent (SWPE) count from the Practice Incentives Program (PIP) Quarterly Payment Advice letter provided by Department of Human Services (DHS).*
2. *Shared Health Summary (SHS) minimum upload target = SWPE * 0.5%*
   ***Note**: For new practice or practice with SWPE < 1,000 the default SWPE count is 1,000.*

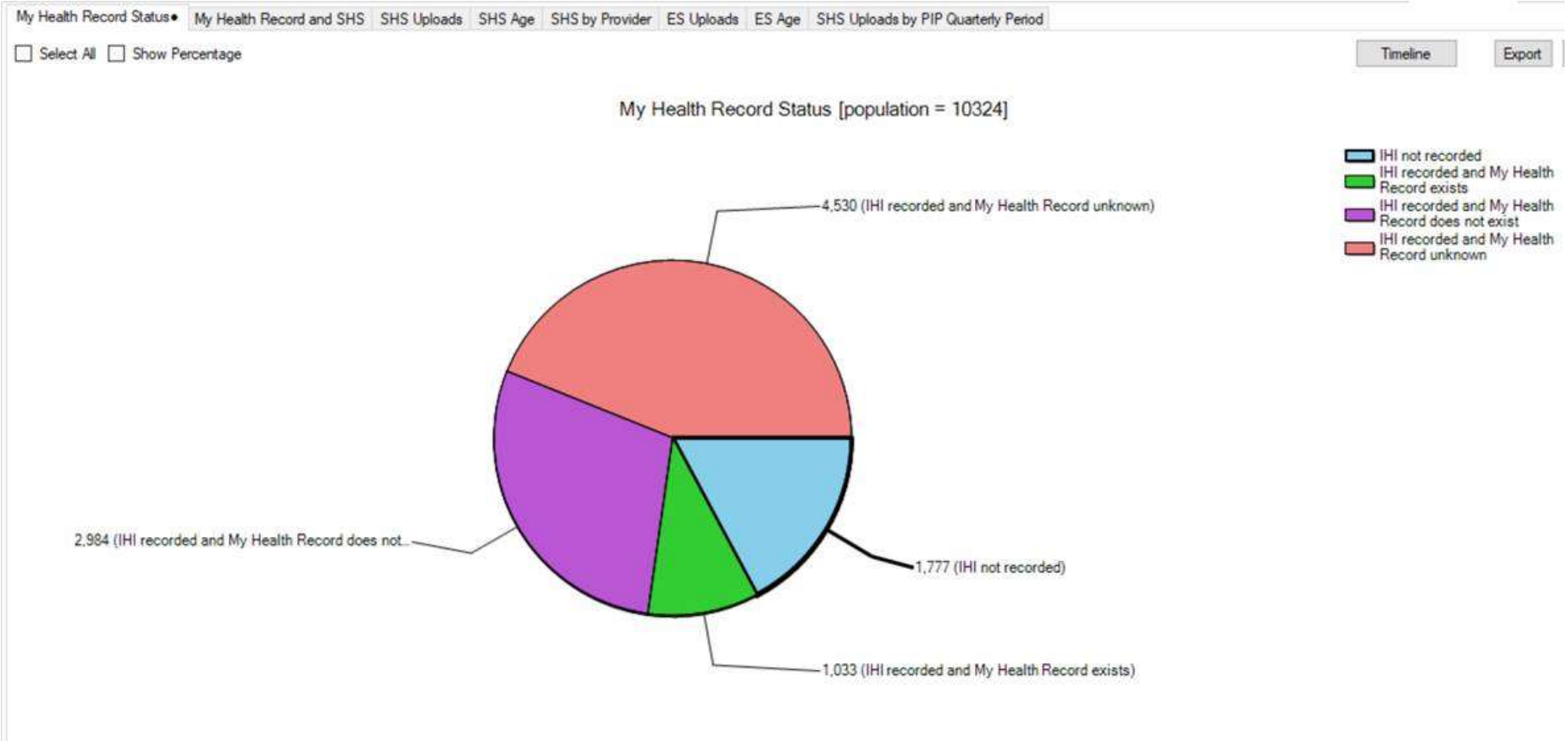
Learn more

https://www.medicaldirector.com/help/#t=topics-ePIP%2FePIP_Shared_Health_Summary_Calculator.htm

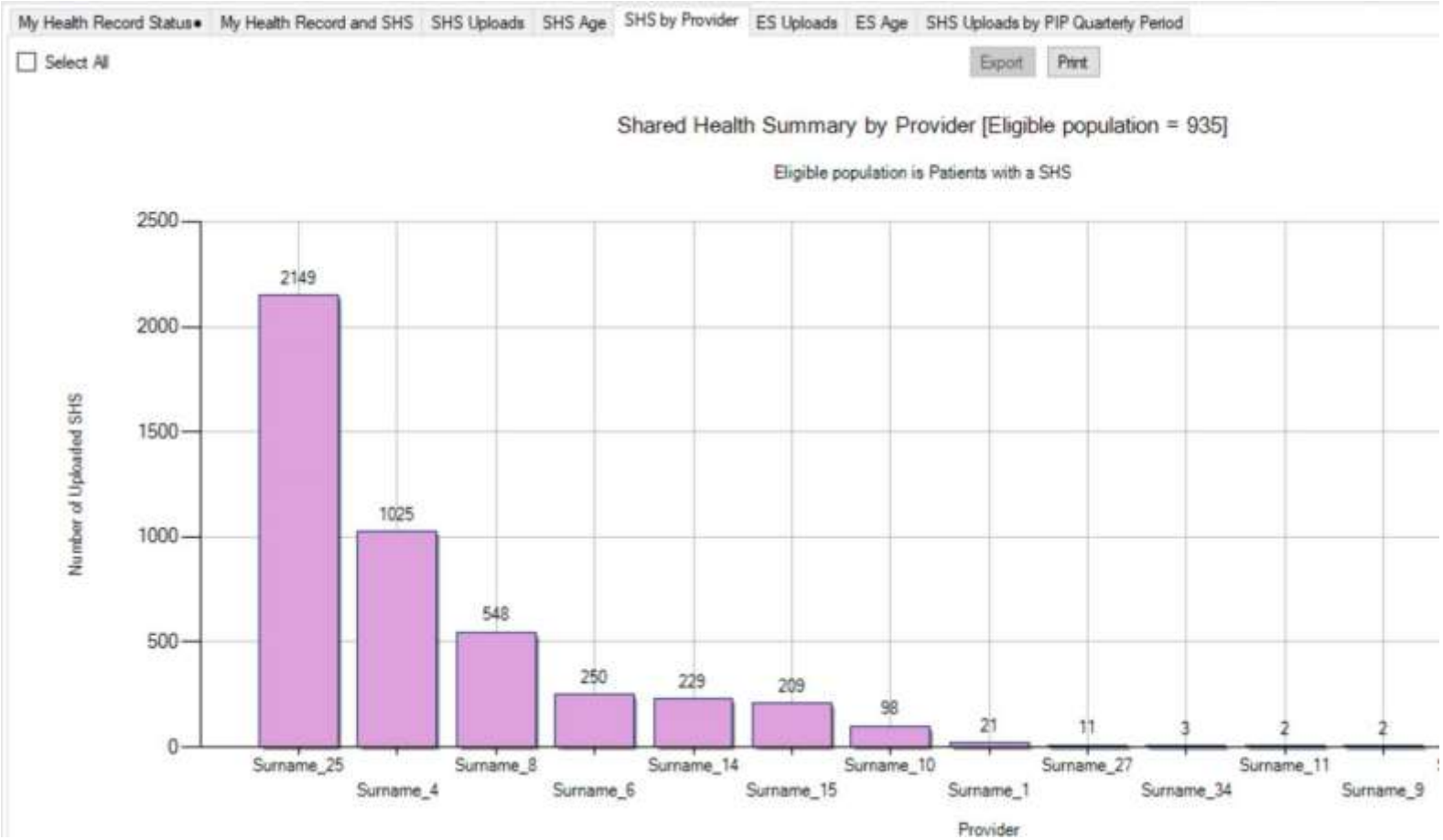
My Health Record Report



My Health Record Reports - CAT4



My Health Record Reports - CAT4



	Whole Practice	GP 1	GP 2	GP 3	GP 4	GP 5	GP 6	GP 7	GP 8	GP 9
1. Allergy Recorded										
Total population	13697	2488	1996	921	1718	1839	936	604	686	43
Nothing recorded	28.8%	16.4	36.5	28.1	51.2	9.4	21.5	24.3	4.1	30.2
Active population	9576	1866	1628	684	1192	1445	795	397	514	30
Nothing recorded	17.7	29.5	28.5	19.7	39.9	4.2	13.8	14.9	01.0	10.0
2. Gender not recorded										
Total population	141	28	11	13	21	6	12	5	6	0
Active population	35	5	2	3	11	2	7	0	3	0
3. Smoking – nothing recorded										
Active population over 16 (Active (3x > 2 years)	27%	15.7	63.9	60.4	76.4	11.5	44.6	41.0	21.2	39.7
4. Recording of ATSI patients										
Total population	0	0	0	1	0	0	0	0	0	0
Active population (Active (3x > 2 years)	1	0	0	1	0	0	0	0	0	0
5. Diabetes Prevalence										
Total population	3.5%	2.9	2.8	1.4	8.8	5.1	2.5	1.2	4.2	4.7
Active population (Active (3x > 2 years)	4.6%	3.8	3.2	1.9	11.7	6.2	2.9	1.8	5.5	6.7
Diabetics 65+, 8+ medications	60.9 %	61.4	74.2%	50%	77.8%	63.6%	81.3%	60%	62.5%	100%
Diabetics 65+, 5+ medications	90.9%	88.7	93.6%	83.4%	92.9%	90.8%	100%	80%	75%	100%
6. Diabetes "at risk" *										
40-49 year olds	94	5	2	3	0	12	2	1	2	0
50+ year olds	288	29	55	6	8	131	10	6	17	1

Next Steps

- Complete Improvement Activity
- Generate report showing how many SHS's have been uploaded
- Access SNPHN learning resources
- Access ADHS online learning modules
- Update practice policy

Thank you for inviting me

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& blog posts
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Keep in touch! With best wishes, Sue Cummins