Meeting Accreditation Standards for Digital Health

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1 September 2016

Learning Objectives

1. Discuss ePIP requirements
2. Explore software ePIP tracking tools
3. Review secure messaging options for health information
4. Discuss coding and implement processes to maximise sharing of essential health information
5. Identify efficient practice workflows for maintaining optimal data quality and curating the health summary

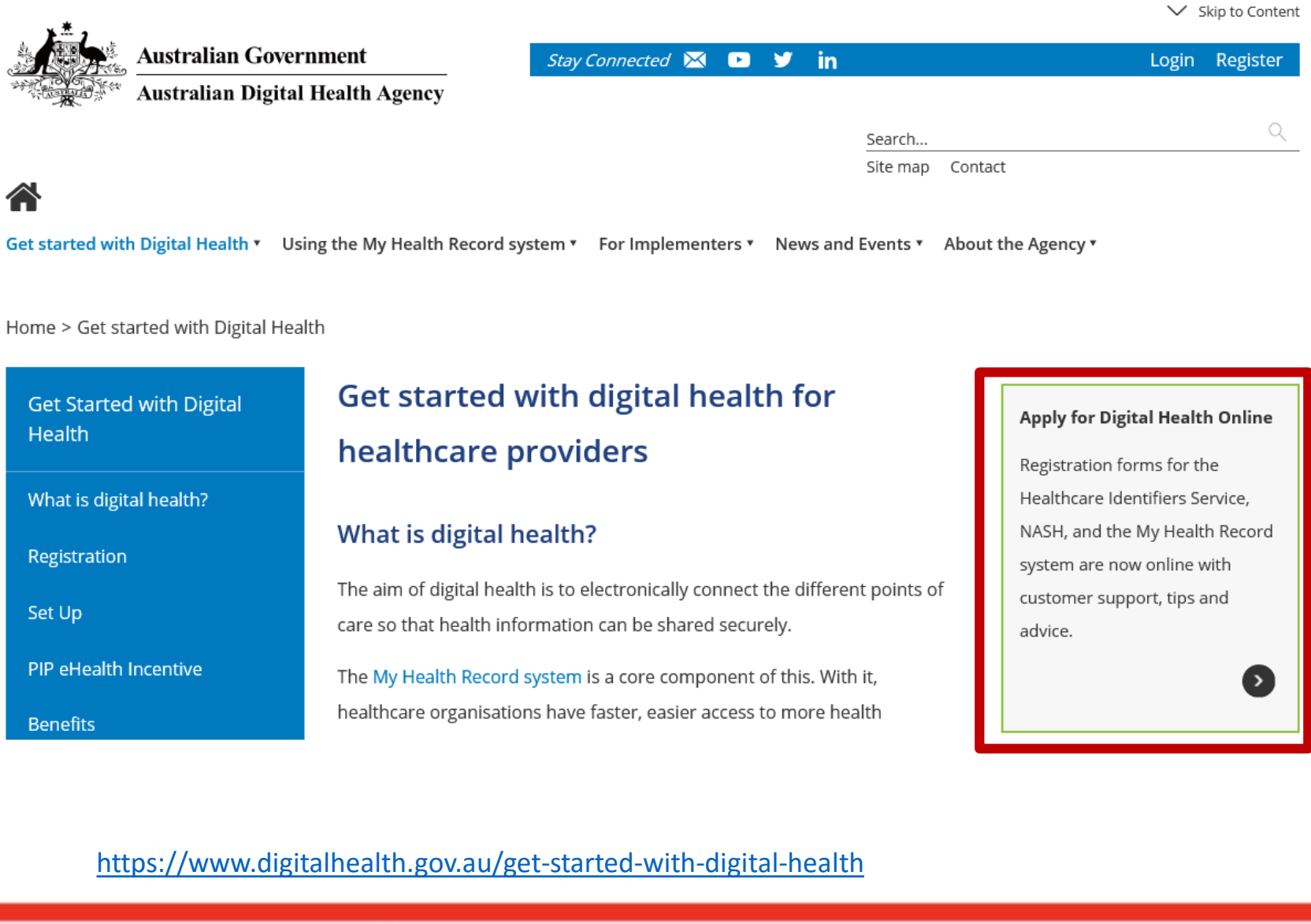
Digital Health Incentive Payment

1. Integrating Healthcare Identifiers
2. Data Records and Clinical Coding
3. ePrescribing
4. Secure Messaging

5. Upload Shared Health Summaries to My Health Record for 0.5% of SWPE

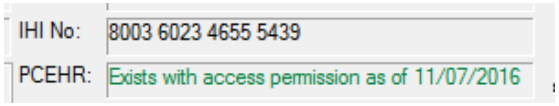
ePIP

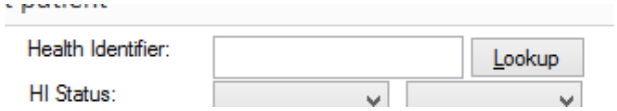
New: Upload requirement per quarter starting 1 May 2016



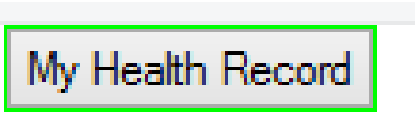
https://www.digitalhealth.gov.au/get-started-with-digital-health

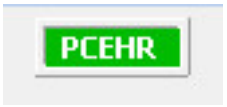
1. Health Identifier





2. My Health Record





Indicators

► A. Our practice has a patient identification process using three approved patient identifiers and the practice team can describe how it is applied.

Explanation

Key points

- Correct patient identification is vital for patient safety and the maintenance of patient confidentiality
- Use at least three approved identifiers for each patient encounter or activity such as making appointments, writing prescriptions, writing referrals to other providers, giving results or entering results or correspondence into records
- Don't assume you have the correct patient record when treating familiar patients
- This criterion cross references to Criterion 1.7.1 Patient health records.

Approved patient identifiers

All practice staff should be trained to check for approved patient identifiers as a matter of course.

Approved patient identifiers are those items of information accepted for use in patient identification and include

- patient name (family and given names)
- date of birth
- gender (as identified by the patient themselves)
- address

http://www.racgp.org.au/your-practice/standards/standards4thedition/safety,-quality-improvement-and-education/3-1/patient-identification/

RACGP Accreditation Standards

4th Standards for General Practices were released 2010
5th Standards currently in consultation phase until 30/9/16
due for release October 2017

http://www.racgp.org.au/your-practice/standards/standardsdevelopment/

Webinar on proposed changes:
http://www.racgp.org.au/your-practice/standards/standardsdevelopment/webinar/

Accreditation Bodies:

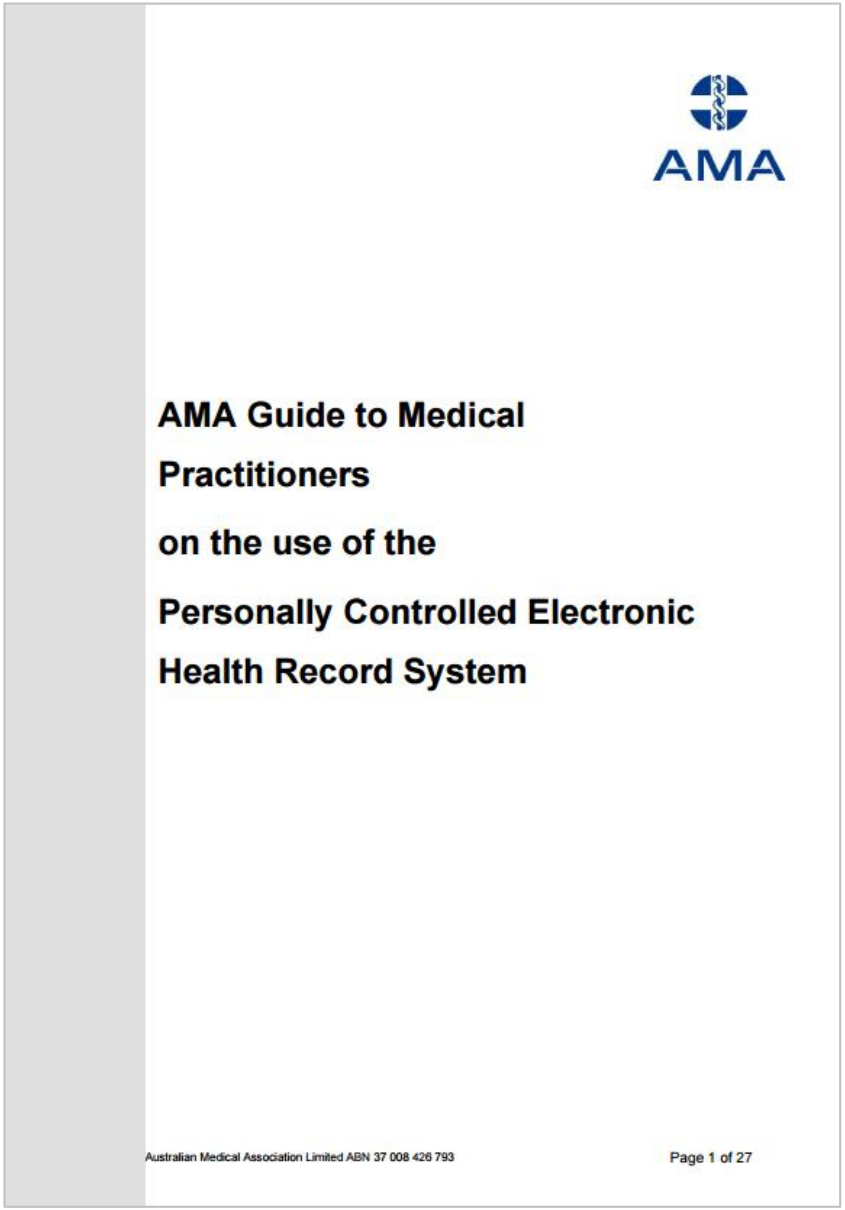
GPA Accreditation*plus*

AGPAL · Accreditation for Practices

Expected standards of use of the My Health Record will develop organically over time.

In absence of these standards, the AMA Guide is a helpful tool that demonstrates the medical profession's expectation of use of the My Health Record.

https://ama.com.au/article/ama-guide-using-pcehr


AMA

AMA Guide to Medical Practitioners on the use of the Personally Controlled Electronic Health Record System

Australian Medical Association Limited ABN 37 008 426 793

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Digital Health Incentive Payment

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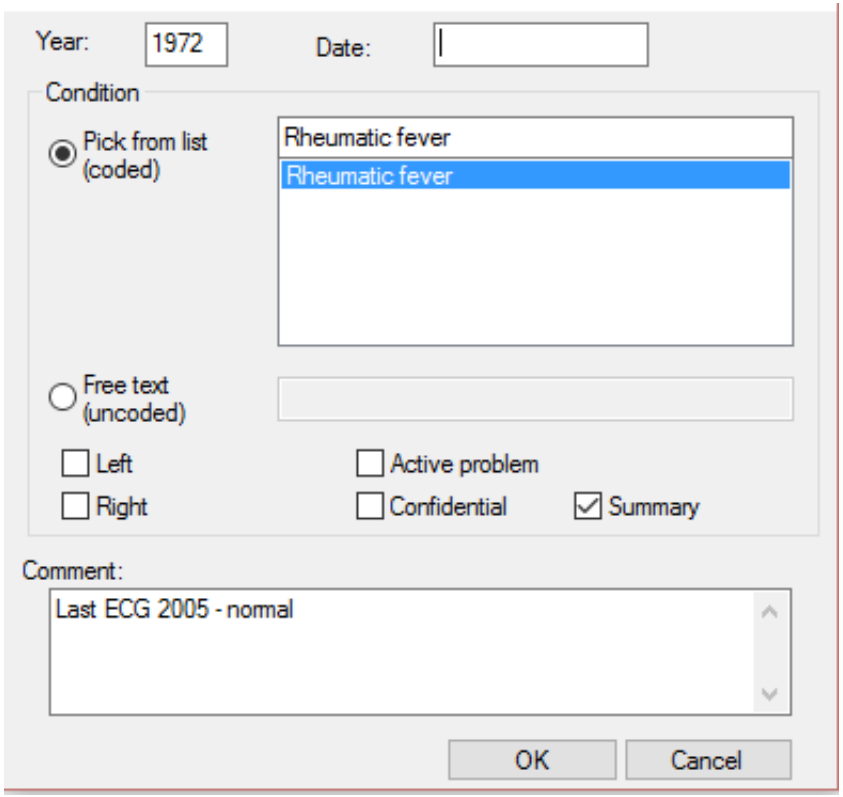
5. Upload Shared Health Summaries to My Health Record for 0.5% of SWPE

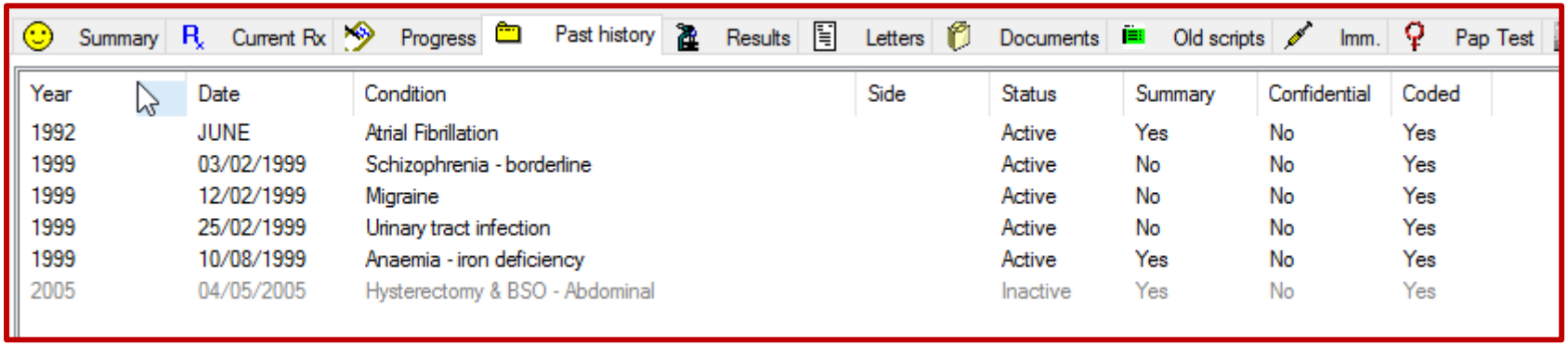
New: Upload requirement per quarter starting 1 May 2016

ePIP

Data Quality tips



- ✓ Include active AND inactive *significant* conditions.
- ✓ Use comment/detail area to add helpful info eg. Specialist looking after this condition, type of surgery etc.
- ✓ Remove duplicated or insignificant 'reasons for contact' eg check-up, phone call, sick feeling etc.
- ✓ Consider changing default settings so 'reasons for visit ' or 'reasons for medication' don't also auto-add to the past medical history list



Year	Date	Condition	Side	Status	Summary	Confidential	Coded
1992	JUNE	Atrial Fibrillation		Active	Yes	No	Yes
1999	03/02/1999	Schizophrenia - borderline		Active	No	No	Yes
1999	12/02/1999	Migraine		Active	No	No	Yes
1999	25/02/1999	Urinary tract infection		Active	No	No	Yes
1999	10/08/1999	Anaemia - iron deficiency		Active	Yes	No	Yes
2005	04/05/2005	Hysterectomy & BSO - Abdominal		Inactive	Yes	No	Yes

"Consistent data **coding** systems drive meaningful quality improvement activities."

1.7.1 Patient Health Records http://www.racgp.org.au/your-practice/standards/standards4thedition/practice-services/1-7/patient-health-records/

Practice workflows for maintaining data quality

Update health summary when actioning incoming correspondence

PATIENT, TEST32E
10 LYON PARK RD, NORTH RYDE. 2113
Phone: 99416416
Birthdate: 19/02/1960 Sex: F Medicare Number:
Your Reference: Lab Reference: 06-2788154-FBS-0
Laboratory: SDS PATHOLOGY
Addressee: HELLO COMPUTER DEPARTMENT Referred by: HELLO COMPUTER DEPARTMENT

Name of Test: FBE
Requested: 01/09/2006 Collected: 01/09/2006 Reported: 01/09/2006 13:27

FULL BLOOD COUNT

	01/09/06 2788154		23/08/06 1283	23/08/06 1282	Range	
Haemoglobin	153		pending	127	(120 - 160)	g/L
RCC	5.18	*	pending	4.09	(3.74 - 5.16)	x10 12/L
Haematocrit	0.481	*	pending	0.393	(0.370 - 0.470)	
MCV	92.9		pending	96.1	(80.0 - 100.0)	fL
MCH	29.5		pending	31.1	(28.0 - 34.0)	pg
MCHC	318		pending	323	(310 - 360)	g/L
RDW	13.5		pending	13.0	(10.0 - 15.0)	%
White cells	5.0		pending	4.9	(4.0 - 11.0)	x10 9/L
Neutrophils	3.0			2.7	(2.0 - 7.5)	"
Lymphocytes	1.5			1.8	(1.0 - 4.0)	"
Monocytes	0.2			0.3	(0.2 - 1.0)	"
Eosinophils	0.3			0.1	(< 0.6)	"
Basophils	0.1			0.0	(< 0.2)	"
Platelets	234		pending	305	(150 - 400)	x10 9/L

1282 Blood count essentially normal.
pending
2788154 Blood count essentially normal.

This result is: Normal, Abnormal, Stable, Acceptable, Unacceptable, Being treated, Under specialist care

Action to be taken: No action, Reception to advise, Nurse to advise, Doctor to advise, Send routine reminder, Non-urgent appointment, Urgent appointment

Store result in: Investigations, Correspondence in, Clinical Images

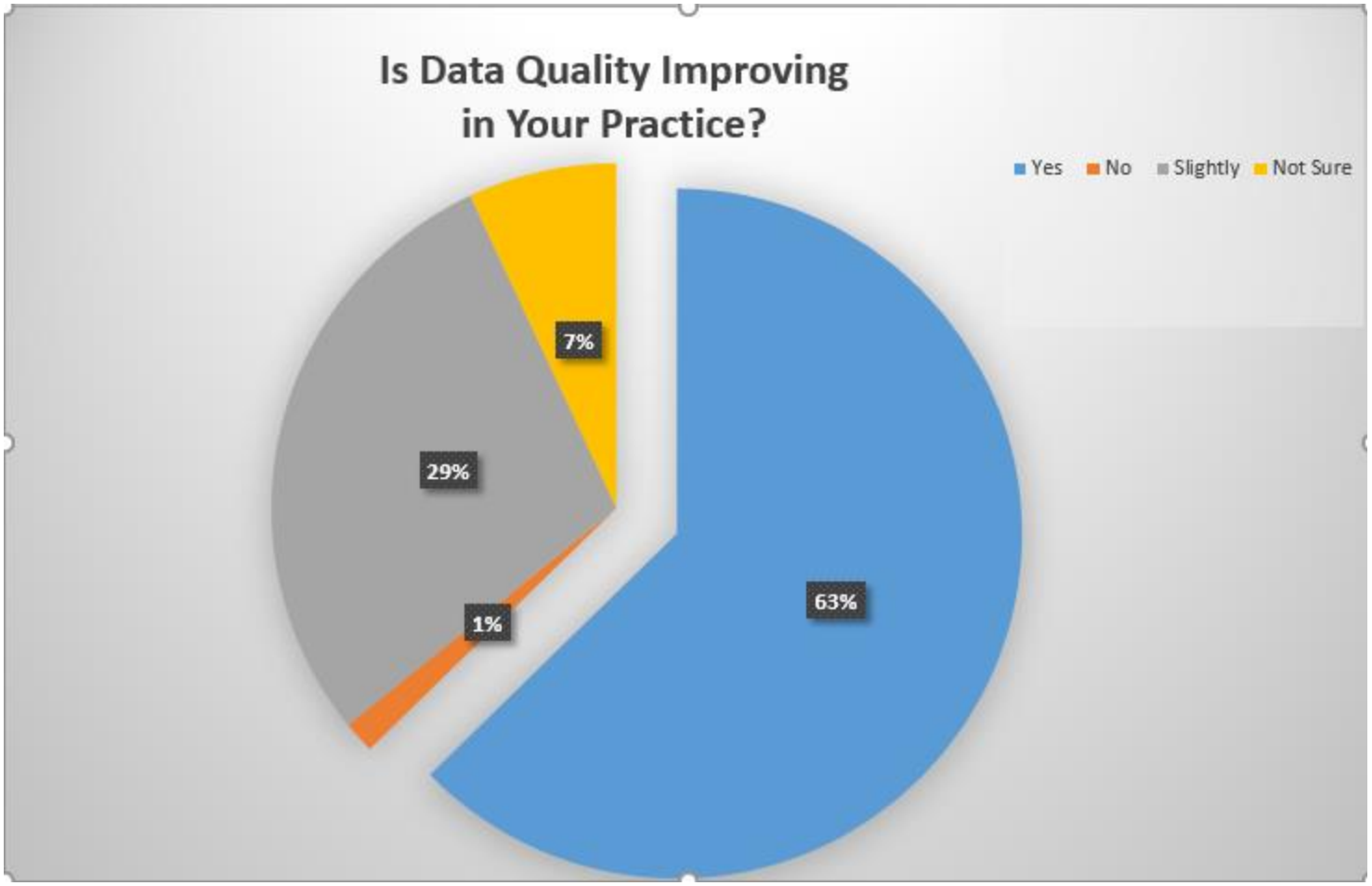
Store for location: Main surgery

Include header

Details

Add Reminder | Add Past History | Add Action | Add Smear | Add INR

< Previous | Next > | Skip | Finish


Is Data Quality Improving in Your Practice?
Yes
No
Slightly
Not Sure
7%
29%
1%
63%

A team approach

1. Practice Managers write the Digital Health policy & train all staff, implement quality improvement activities.
2. Receptionists register patients for a My Health Record.
3. Registrars & nurses may be able to help clean up data
4. Nurses, Registrars, GPs & Aboriginal Health Practitioners can upload to the My Health Record.

RACGP Standards

A. Our practice can demonstrate that at least 90% of our active patient health records contain a record of known allergies.

B. Our practice can demonstrate that **at least 75%** of our active patient health records contain a **current health summary.**

C. Our practice has documented standardised clinical terminology (such as coding)...

http://www.racgp.org.au/your-practice/standards/standards4thedition/practice-services/1-7/health-summaries/

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ePIP

New: - Upload requirement per quarter starting 1 May 2016

Secure Messaging Delivery

- To use SMD both the sending and receiving parties must use compatible encryption processes. SMD is technically complex and does not need to be understood by practices as SMD vendors must conform to Australian standards.

- SMD can be either P2P (point-to-point), where information is sent from a specific sender to a specific recipient or recipients, or P2shared (point-to-shared), where information is sent from a specific sender to a shared record such as with the national eHealth record system.

Computer and Information Security Standards

http://www.racgp.org.au/your-practice/standards/computer-and-information-security-standards/standard-12

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Websites for further learning

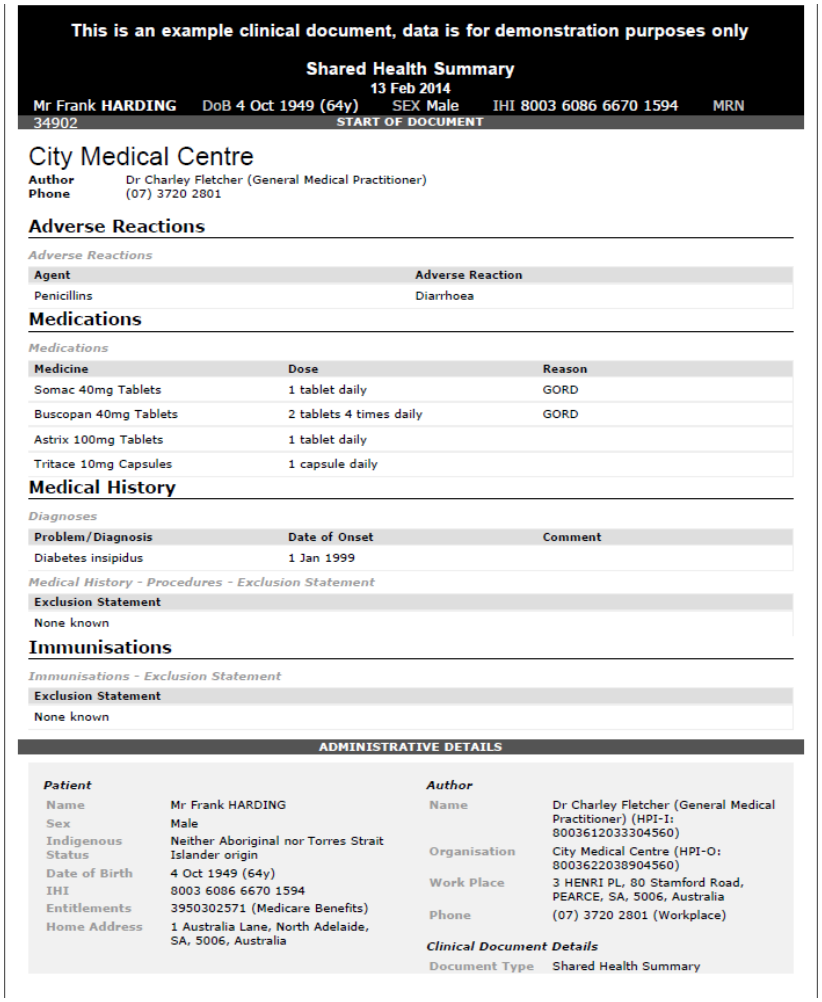
www.myhealthrecord.gov.au

www.digitalhealth.gov.au

Training for My Health Record use

1. Complete the free eLearning Modules
   https://myhealthrecord.e3learning.com.au/
2. Download the 'guides' for your software
   https://www.digitalhealth.gov.au/using-the-my-health-record-system/digital-health-training-resources/guides
3. Watch the software demonstration for your software
   https://www.digitalhealth.gov.au/using-the-my-health-record-system/digital-health-training-resources/software-demonstrations
4. Practise in the 'On-Demand' Training Environment
   https://www.digitalhealth.gov.au/using-the-my-health-record-system/digital-health-training-resources/on-demand

Shared Health Summary



This is an example clinical document, data is for demonstration purposes only

Shared Health Summary
13 Feb 2014

Mr Frank **HARDING** DoB 4 Oct 1949 (64y) SEX Male IHI 8003 6086 6670 1594 MRN 34902

START OF DOCUMENT

City Medical Centre

Author Dr Charley Fletcher (General Medical Practitioner)
Phone (07) 3720 2801

Adverse Reactions

Adverse Reactions

Agent	Adverse Reaction
Penicillins	Diarrhoea

Medications

Medications

Medicine	Dose	Reason
Somac 40mg Tablets	1 tablet daily	GORD
Buscopan 40mg Tablets	2 tablets 4 times daily	GORD
Astrix 100mg Tablets	1 tablet daily	
Tritace 10mg Capsules	1 capsule daily	

Medical History

Diagnoses

Problem/Diagnosis	Date of Onset	Comment
Diabetes insipidus	1 Jan 1999	

Medical History - Procedures - Exclusion Statement

Exclusion Statement
None known

Immunisations

Immunisations - Exclusion Statement

Exclusion Statement
None known

ADMINISTRATIVE DETAILS

Patient

Name	Mr Frank HARDING
Sex	Male
Indigenous Status	Neither Aboriginal nor Torres Strait Islander origin
Date of Birth	4 Oct 1949 (64y)
IHI	8003 6086 6670 1594
Entitlements	3950302571 (Medicare Benefits)
Home Address	1 Australia Lane, North Adelaide, SA, 5006, Australia

Author

Name	Dr Charley Fletcher (General Medical Practitioner) (HPI-I: 8003612033304560)
Organisation	City Medical Centre (HPI-O: 8003622038904560)
Work Place	3 HENRI PL, 80 Stamford Road, PEARCE, SA, 5006, Australia
Phone	(07) 3720 2801 (Workplace)

Clinical Document Details

Document Type	Shared Health Summary

1. Adverse Reactions
2. Medications
3. Medical History
4. Immunisations

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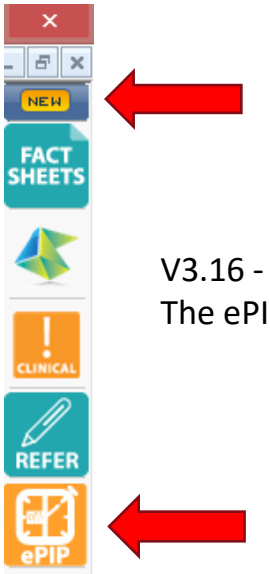
How do you upload a Shared Health Summary?

1. Watch the software demonstration for your software
   https://www.digitalhealth.gov.au/using-the-my-health-record-system/digital-health-training-resources/software-demonstrations

2. Practise in the 'On-Demand' Training Environment
   https://www.digitalhealth.gov.au/using-the-my-health-record-system/digital-health-training-resources/on-demand

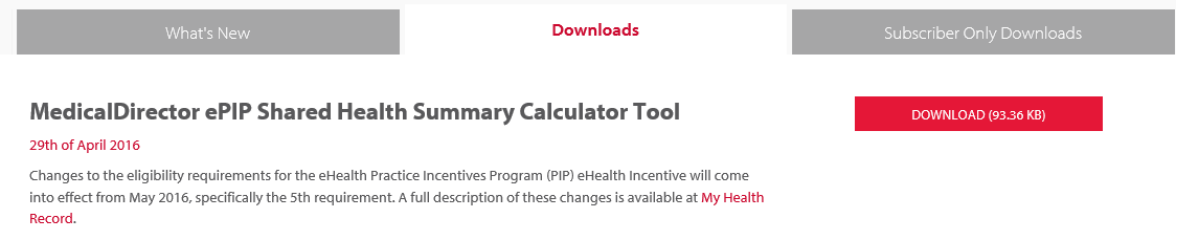
Optional: Download the 4 step cheat sheet for your software
https://www.digitalhealth.gov.au/using-the-my-health-record-system/digital-health-training-resources/guides

ePIP tracking tool - MedicalDirector

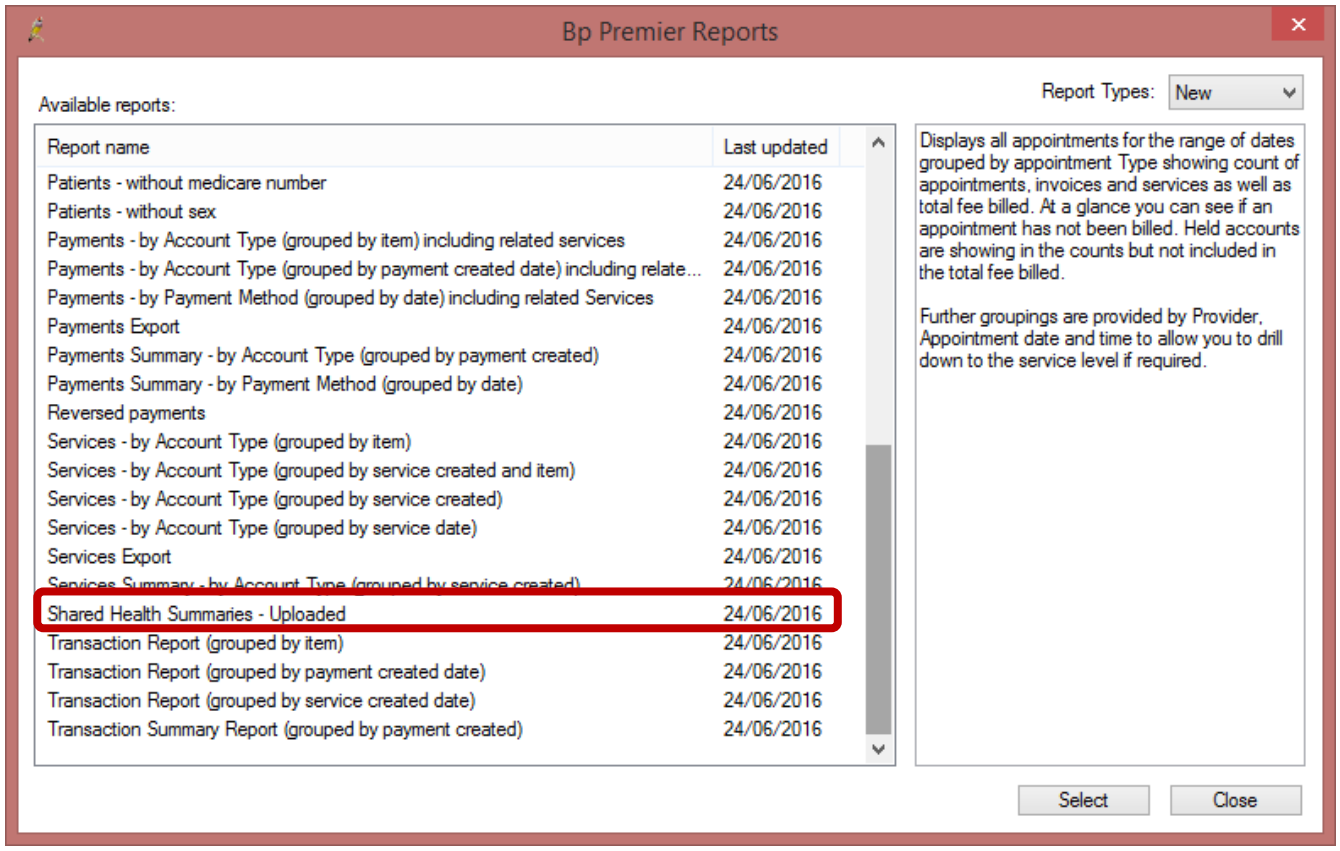


V3.16 - download
The ePIP widget

If using v3.15 – download from
www.medicaldirector.com.au



ePIP tracking tool –Bp Premier



Management > Reports > Shared Health Summaries

Create a culture of Data Quality Improvement in your practice

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C. Our practice has documented standardised clinical terminology (such as **coding**).

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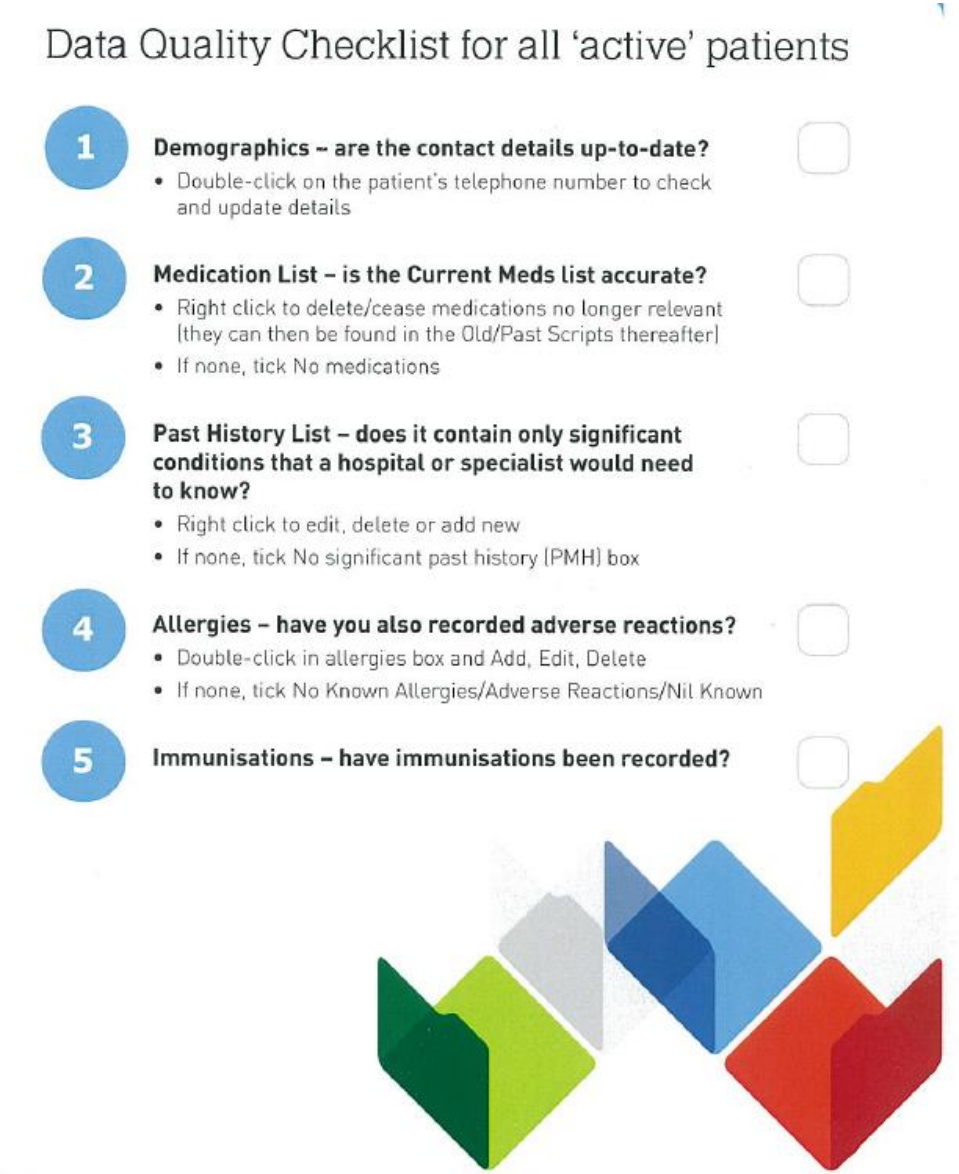
Download the Data Quality checklist



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?**

Demographic Data Quality Improvement Tools

73% of **self-check-in** patients identified **incorrect** demographic information in their patient record

Clinical Data Quality Improvement Tools

- ✓ Doctors Control Panel
- ✓ Canning Tool
- ✓ Pen CAT4
- ✓ MedicalDirector Insights
- ✓ Best Practice SQL queries
- ✓ Polar/Grhanite

RACGP Accreditation Standards

Quality Improvement Module

QI 1.3B

Our practice team implements activities

aimed at **improving clinical practice.**

This criterion in the 4th edition did not have any indicators associated with it.

New standards will have indicators.

Reflecting importance of a team-based practice approach.

Safety & Quality Standards

Clinical Governance:
– actively promoting and encouraging safe and high-quality clinical care through clear policies, guidelines and accountability

http://www.racgp.org.au/your-practice/standards/interpretiveguide4thedition/safety,-quality-improvement-and-education/3-1/overview/

Internal Validating Processes

Extract from Garden Valley Medical Practice Clinical Coding Practice Manual

1. Routine audits should be completed to determine the level of data quality within the practice

2. Confirming and asking different members of staff whether they understand different aspects of clinical coding from the creation of the manual

3. Each member of staff and healthcare professional should be able to routinely follow the 'Coding Cycle' in association with their own individual duties and responsibilities (previously outlined in section 2.1 of manual).

4. This manual should be updated and new or increasingly relevant information should be added annually to ensure that information is kept up to date accordingly. This is the responsibility of the Clinical Care Coordinator

5. Six monthly Chronic Disease Board meetings should include clinical coding within the agenda to assess and evaluate any strategical changes or new ideas to be incorporated into the practice's clinical coding protocol. Each member of staff's thoughts and ideas on clinical coding for different relevant aspects to their profession should be considered and accounted

Patient right to access personal information

- Patient right to access is different from a healthcare provider's intellectual property rights over the clinical document

- Right of access set out in privacy legislation

> **Australian Privacy Principle 12 — access to personal information**
>
> *Access*
>
> 12.1 If an APP entity holds personal information about an individual, the entity must, on request by the individual, give the individual access to the information.

https://www.oaic.gov.au/individuals/privacy-fact-sheets/general/privacy-fact-sheet-17-australian-privacy-principles#australian-privacy-principle-12-access-to-personal-information

Patient right to correction of personal information

- Right of access correction of personal information set out in privacy legislation:

Australian Privacy Principle 13 — correction of personal information

Correction

13.1 If:

a. an APP entity holds personal information about an individual; and

b. either:

i. the entity is satisfied that, having regard to a purpose for which the information is held, the information is inaccurate, out of date, incomplete, irrelevant or misleading; or

ii. the individual requests the entity to correct the information;

the entity must take such steps (if any) as are reasonable in the circumstances to correct that information to ensure that, having regard to the purpose for which it is held, the information is accurate, up to date, complete, relevant and not misleading.

https://www.oaic.gov.au/individuals/privacy-fact-sheets/general/privacy-fact-sheet-17-australian-privacy-principles#australian-privacy-principle-12-access-to-personal-information

Integrity of personal information

- Existing obligation to keep personal information accurate, up-to-date and complete set out in privacy legislation:

Australian Privacy Principle 10 — quality of personal information

10.1 An APP entity must take such steps (if any) as are reasonable in the circumstances to ensure that the personal information that the entity collects is accurate, up-to-date and complete.

10.2 An APP entity must take such steps (if any) as are reasonable in the circumstances to ensure that the personal information that the entity uses or discloses is, having regard to the purpose of the use or disclosure, accurate, up-to-date, complete and relevant.

https://www.oaic.gov.au/individuals/privacy-fact-sheets/general/privacy-fact-sheet-17-australian-privacy-principles#australian-privacy-principle-12-access-to-personal-information

Existing obligations with sharing information

Exercising appropriate care and skill when **sharing health information**

Exercising appropriate care and skill when **relying on third party information**

For success

1. **Build critical mass**

   Help your patients register so the majority have a My Health Record.

2. Start routinely viewing and uploading health summaries to the My Health Record system.

Embed into routine clinical and administrative workflow.

Contact the Agency

Help Centre:	**1300 901 001**
	8am-6pm Monday to Friday
Email:	**help@digitalhealth.gov.au**
Website:	**www.digitalhealth.gov.au**
Twitter:	**https://twitter.com/AuDigitalHealth**

Thank you for attending today's webinar