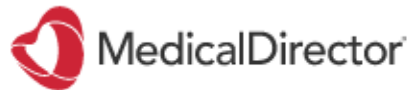


Digital Health in Practice



Presented by Sue Cummins
Train IT Medical Pty Ltd
www.trainitmedical.com.au
sue@trainitmedical.com.au

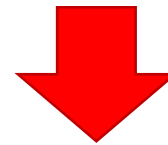
Learning Objectives:

- 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

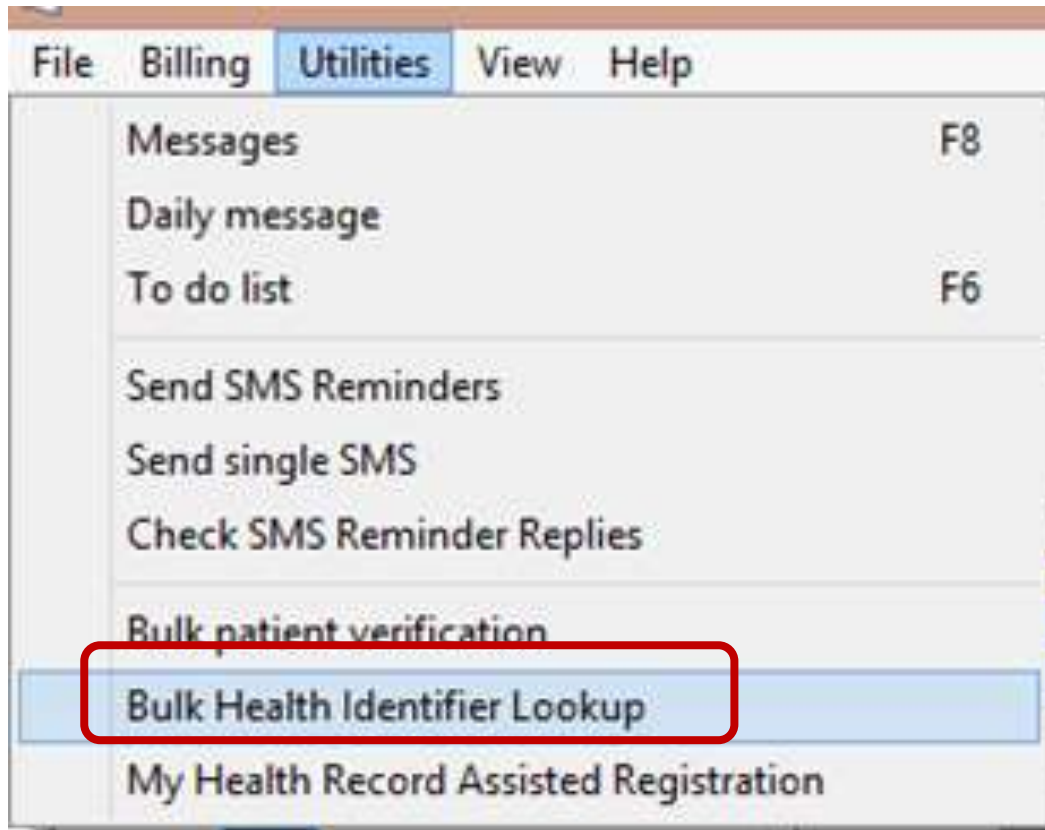


MD checks automatically if patient has an IHI and My Health Record

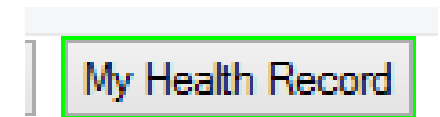
A screenshot of a medical software interface. The top menu bar includes "maries", "Tools", "Clinical", "Correspondence", "Assessment", "Resources", "Sidebar", "MyHealthRecord", "Window", and "Help". Below the menu is a toolbar with various icons. The main area displays patient information: "DOB: 15/03/1979", "Gender: Male", "Occupation:", "Ph:", "Record No:", "ATSI: Aboriginal", "Pension No:", "Ethnicity: Australian Aboriginal", "Smoking Hx: ? Smoker", "IHI No: 8003 6081 6669 0511", and "MyHealthRecord: Exists with access permission as of 26/02/2017". A red box highlights the IHI number and the MyHealthRecord status. A "Go MDRefer" button is visible in the top right corner of the interface.

▼	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		

IHI Validation - Bulk



Will put green box if patient has a My Health Record



Practise in the 'On Demand' test environment

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



ON DEMAND TRAINING

Our digital health training tool – no booking required.

Learn how to use the My Health Record system in real time using a simulated version of your clinical software.

You can upload a Shared Health Summary, view a My Health Record, and more!



Best Practice ODT

Communicare ODT

Consumer Portal ODT

Fred Dispense ODT

Genie ODT

Medical Director ODT

Zedmed ODT

[Go to On Demand Training Environment](#)

View your patient's My Health Record



MedicalDirector

aries Tools Clinical Correspondence Assessment Resources Sidebar MyHealthRecord Window Help

BP Ph: Record No: ATSI: Aboriginal
DOB: 15/03/1979 Gender: Male Occupation: On 10s
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 3553-6666
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
Phenoxyethylpenicillin	• 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

File:///C:/Users/Administrator/AppData/Local/Genis/Solo_2122187938/TempDocs/CDA_69_2_25_173366225455623862818303389193566077302/DHE_XDM/SUBSET01/CDA_ROOT.html
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 at a Travel Clinic
- 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.

<https://www.myhealthrecord.gov.au/shared-health-summaries-versus-event-summaries>

Privacy Controls and Patient View

The screenshot displays the 'My Health Record' patient portal interface. At the top, the Australian Government logo and 'My Health Record' branding are on the left, and the user's name 'BRIANNA CURTIN' and birth date 'Born 20-May-1998' are on the right. A navigation bar below the header includes 'RECORD HOME', 'DOCUMENTS' (highlighted with a red arrow), 'PRIVACY & ACCESS', and 'PROFILE & SETTINGS'. On the right side of the navigation bar are 'SEARCH' and 'HELP' icons. The main content area starts with a '< Back' link. The title 'Clinical Records' is prominently displayed, followed by a descriptive sentence: 'These are documents with clinical information entered by healthcare providers in My Health Record.' Below this, there are six categorized boxes: '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), and '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:0455555555

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

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

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

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.

[Factsheet: Pathology Reports for Clinicians](#)

www.racgp.org.au

Quality patient information



Lab Tests Online^{AU}
EXPLAINING PATHOLOGY

<https://www.labtestsonline.org.au>



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

Apps that connect to My Health Record:

	HealthEngine HealthEngine Pty Ltd	More information about HealthEngine
	Healthi Chemonix 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:

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:

Send to My Health Record

Confidential

Include in summaries

✓ Only for chronic conditions & significant events

✓ Significant active or inactive conditions

✓ Add detail

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

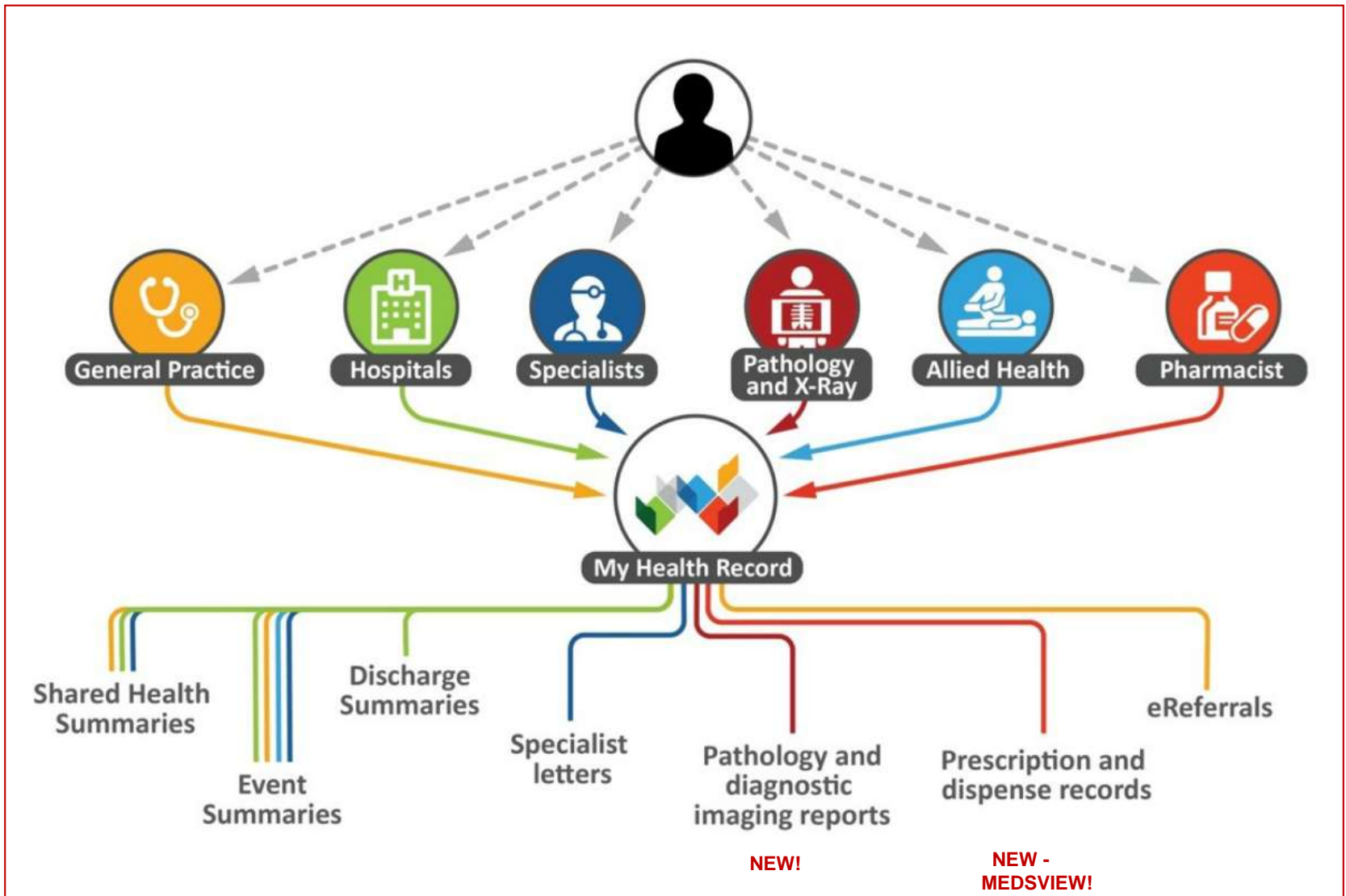
[Download the 'Data Quality' Checklist](#)

– 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

Clinical Data Statistics ✕

Percentage of active patients who have been asked about:

<input type="checkbox"/> Allergies / Adverse Drug Reactions	86.67%
<input type="checkbox"/> Current Medications	60.00%
<input type="checkbox"/> Past Medical History	93.33%

To view the list of active patients who have not been asked about this information, select your preferences from the options provided above and click the Patients Details button.

Selecting multiple options uses the logical operator 'AND' to display a list of active patients who do not have ALL of the selected criteria.

QI Activity:

QUALITY IMPROVEMENT TOOLKIT RESOURCES



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 <ul style="list-style-type: none"> ▪ 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)		<i>List ideas here to work on in table below</i> 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.				

	Whole Practice	GP 1	GP 2	GP 3	GP 4	GP 5	GP 6	GP 7	GP 8	GP 9
1. Allergy Recorded										
<u>Total population</u>	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
<u>Active population</u>	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										
<u>Total population</u>	141	28	11	13	21	6	12	5	6	0
<u>Active population</u>	35	5	2	3	11	2	7	0	3	0
3. Smoking – nothing recorded										
<u>Active population over 16</u> (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										
<u>Total population</u>	0	0	0	1	0	0	0	0	0	0
<u>Active population</u> (Active (3x > 2 years))	1	0	0	1	0	0	0	0	0	0
5. Diabetes Prevalence										
<u>Total population</u>	3.5%	2.9	2.8	1.4	8.8	5.1	2.5	1.2	4.2	4.7
<u>Active population</u> (Active (3x > 2 years))	4.6%	3.8	3.2	1.9	11.7	6.2	2.9	1.8	5.5	6.7
<u>Diabetics 65+, 8+ medications</u>	60.9 %	61.4	74.2%	50%	77.8%	63.6%	81.3%	60%	62.5%	100%
<u>Diabetics 65+, 5+ medications</u>	90.9%	88.7	93.6%	83.4%	92.9%	90.8%	100%	80%	75%	100%
6. Diabetes “at risk” *										
<u>40-49 year olds</u>	94	5	2	3	0	12	2	1	2	0
<u>50+ year olds</u>	288	29	55	6	8	131	10	6	17	1

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	<input type="text" value="1000"/>	5	0
Feb to Apr 30	FEB	<input type="text" value="1000"/>	5	0
May to Jul 31	MAY	<input type="text" value="1000"/>	5	0
Aug to Oct 31	AUG	<input type="text" value="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



Clinic Summary Demo - POLAR x +

https://polarexplorer.org.au/Reports/ShowQap/4121?reload=1#

POLAR Clinic Summary - MHR Reports Dashboard Patients Clinical MBS Practice Help Patient List Bookmarks

No selections applied

Double click to view list

Patient Count
12,869 5,996 active

Uploaded SHS

105

UPLOADED SHARED HEALTH SUMMARIES

PIP Year	PIP Quarter	Uploaded SHS
Totals		105
2018	2018 - Q3	7
2018	2018 - Q2	12
2018	2018 - Q1	18
2017	2017 - Q4	16
2017	2017 - Q3	11
2017	2017 - Q2	9

2017

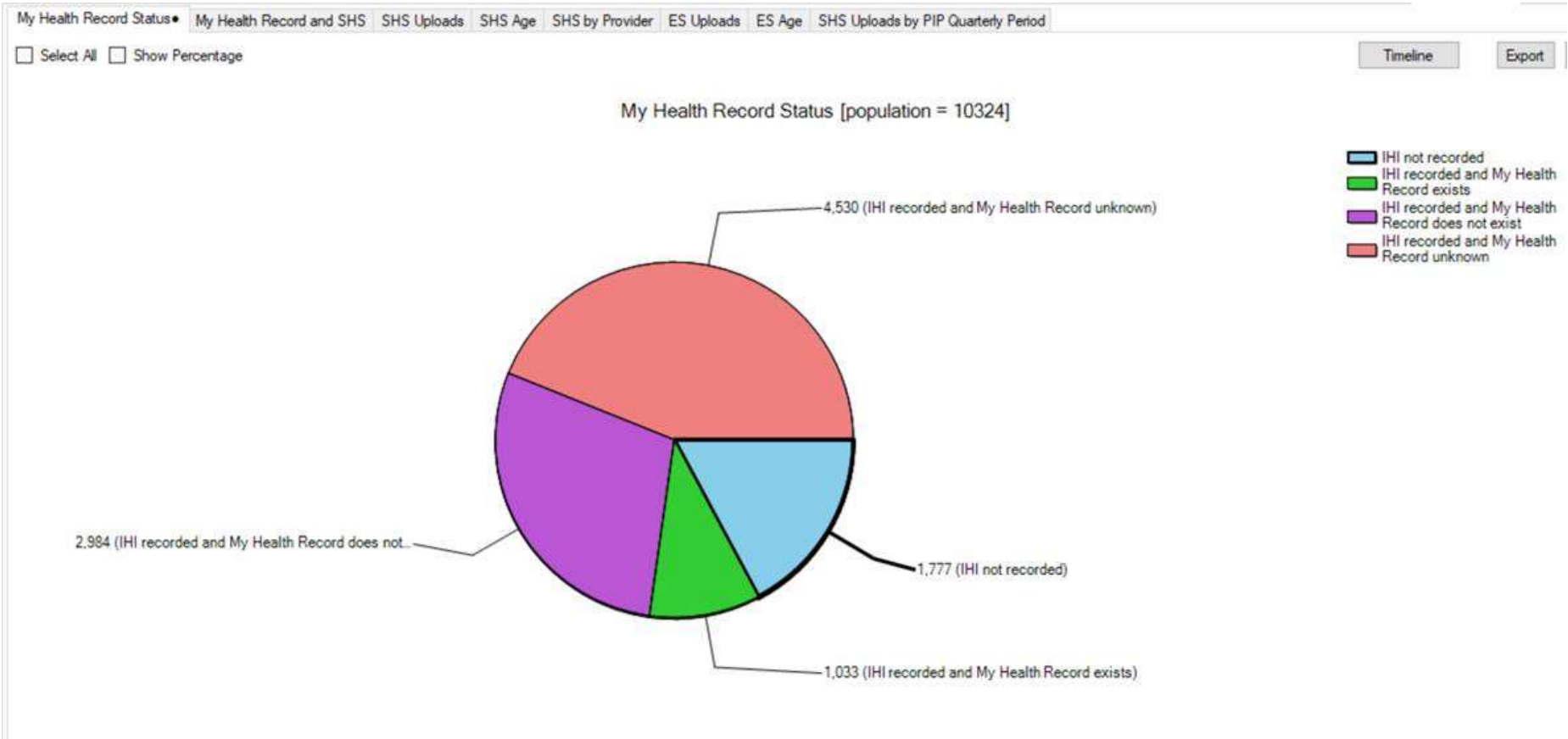
UPLOADED SHARED HEALTH SUMMARIES

SHARED HEALTH SUMMARY PATIENT ACTIVITY

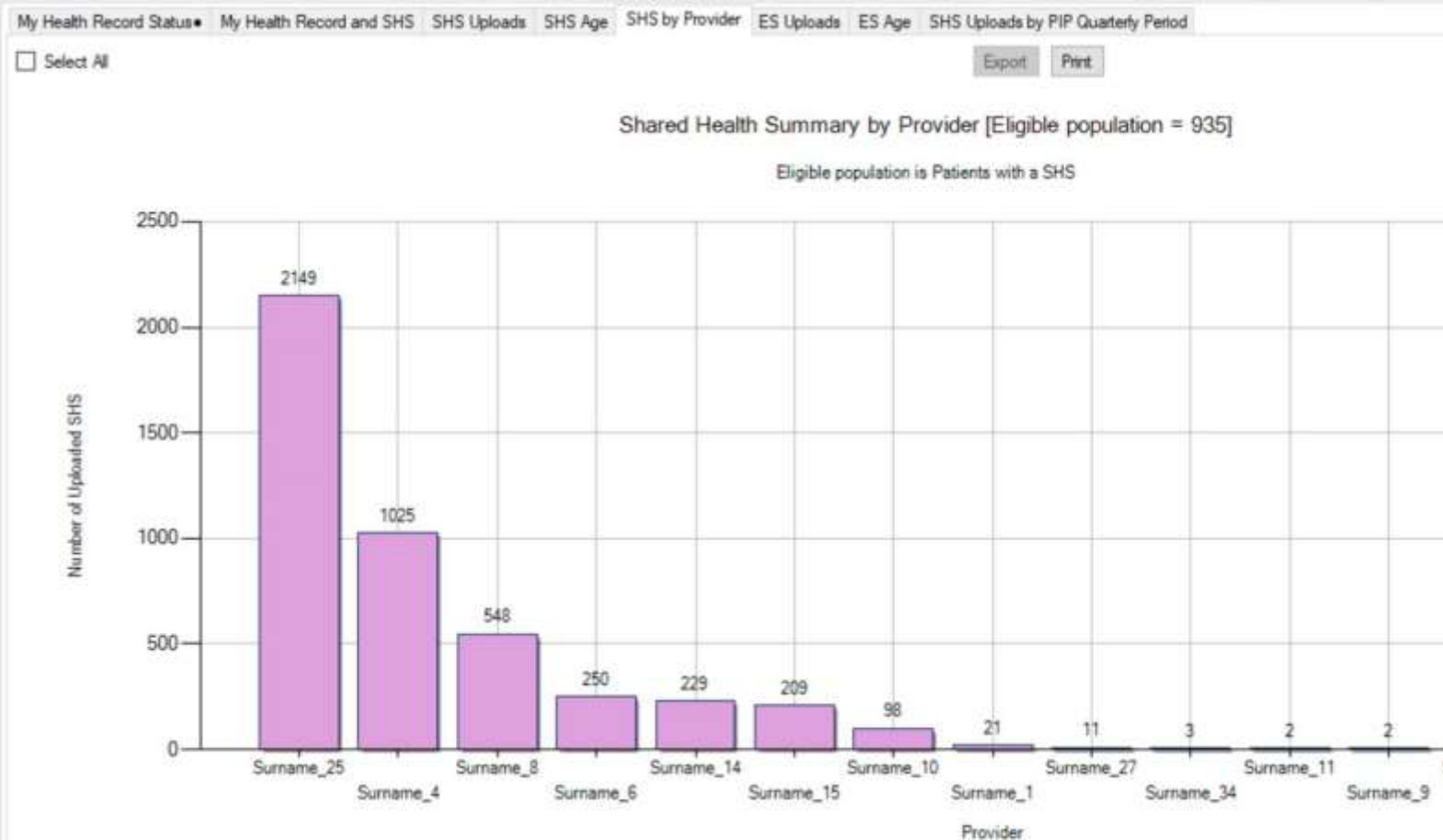
Patient ID	Full Name	Last SHS Access Date	SHS Accou Cou
Totals		27/06/2018	14
1573	Adrio, Amantina	27/06/2018	
1368	Amoraga, Christof	19/06/2018	
2877	Adamsen, Alexey	1/06/2018	
24958	Astor, Florita	1/06/2018	

Windows taskbar: ENG 9:46 AM

My Health Record Reports - CAT4



My Health Record Reports - CAT4



Next Steps

- Generate report showing how many shared health summaries have been uploaded
- Complete Improvement Activity
- [Access SNPHN learning resources](#)
- [Access My Health Record online learning modules](#)
- Update your practice policy.
- Train your staff!

Thank you for inviting me

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www.trainitmedical.com.au

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Keep in touch! With best wishes, Sue Cummins