

PracSavvy

Clinical Systems Support and Training

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July 2022 — Newsbrief

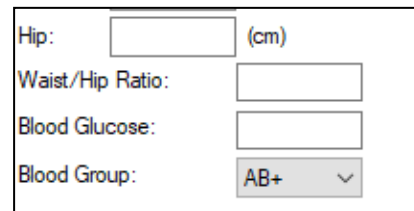
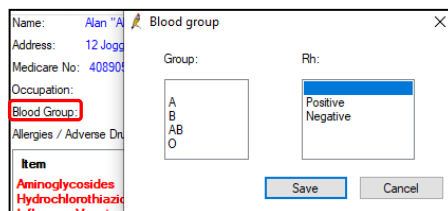
Welcome to this month's PracSavvy newsletter. By now practices will be getting used to the *idiosyncrasies* of the web services updates for BP and MD. Interestingly, at the proverbial 11th hour, users of both MD and BP had the deadline for software updates extended to the end of August. I imagine though, that most if not all Tasmanian practices have done their upgrades by this point.

In truth most of the issues seem to be concerned with Medicare batches and claiming. The take away message seems to be, to avoid using any non alpha characters in the service text or Item descriptions. So no /@# etc, even double spaces seem to have caused rejection messages. Similarly no unexpected characters to be used in patient demographic fields. So, having the value of "none" in a patients home phone field, may well cause you a problem. I think most problems can be grouped under this issue, although I've also heard that Medicare systems have also been running a little flaky of late.

The new Immunisation Register functionality has been really good, especially the ability to download "given elsewhere" from AIR to the patient record. There is however, an MD bug where an uploaded vaccine can only be edited by the GP it was given on behalf of, not by the nurse that made the entry and gave the vaccine. Remember to get [Location Provider number](#) from AIR and insert it into your software so nurses can access the full AIR functionality.

On a bit of a random note I'm aware that there is some [initial research](#) on the link between a persons blood type and their risk of contracting Covid-19. There has always been a field for recording blood group in GP software, but it's rarely been utilised. I did a spot check at a couple of really big GP databases and the recording of this information was at around 1% or less of patients. There is a good reason for this of course as it appears GPs don't really need this information.

Possibly it may be worth recording this information? This is after all, the patient's medical record, so it seems like a reasonable idea. It may even pass muster as a Quality Improvement (QI) initiative. As illustrated below, BP has a spot in the *demographics* that you can double-click on, whereas MD has an area on the *Examination..General* tab, where it retains the entered value for future use. BP let's you readily search on blood group, whereas MD doesn't, because, well it's MD.



I have no idea really whether this is worthwhile now or in our pandemic aware future. I did once see a ~~fascinating documentary~~ X-files episode where patients of a certain blood type were instrumental in combatting a plague.

eReferral

Please update your address books with the following changes, remembering my full list can always be found [here](#).

Leonie Coskun	Psychology	<i>lmc32lmc</i>	<i>Delete</i>
Dr Thomas Bonnelame	Ophthalmology	<i>hobareye</i>	<i>Delete (Retired)</i>

Templates

The following new or updated templates are available at my website [here](#):

- ◆ Community Continence Service - Statewide Referral
- ◆ Precision - Electrodiagnostic Clinic Referral
- ◆ Cardiology Tasmania will **soon** have updated versions of their request template at their website [here](#).

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Continuing a recent habit of attempting to demystify tech concepts, I thought I'd talk a little about "the cloud". You may have had your IT guy/gal breathlessly extoling the virtues of being "in" this, and you may or may not think that you can only do this if you swap to MD Helix. The best way to talk about this is to step through the evolution of practice connectivity to where we are today. This may be a bit ho-hum for corporate practice types, but it may also leave the smaller practice owners or managers more confident to have the conversation.

So, a stab at a history of practice connectivity methods:

Method 1) In the beginning, the multi doctor practice had a server in the building with the Clinical database e.g. MD/BP/ installed on it. All the staff had machines that were connected to the server via their blue cables or sometimes WiFi. These pcs had workstation versions of MD/BP etc installed and they were configured to point to the database on the server to access the data. In this model IT support staff had to visit every workstation every time there was a BP/MD update.

Method 2) As Servers became more powerful, practices changed to a method where BP/MD was ONLY installed on the server and the GP workstations would be configured to connect to this machine via blue cable etc and then sign in *again* at the server where they would be able to access their software from their login desktop and fully utilise the power of the server. It was like they were sitting at the server themselves. This method was originally referred to as "Terminal Server" although "Remote Desktop" is now more commonly used.

The advantage to this was that the workstations could now be quite basic, only really needing to be able to make a windows type connection to the server. The Server was the only machine that really counted, and any MD/BP updates only needed to be installed on the server and under the individual login profiles. That's why a lot of software gives the option "install for all users"

Method 3) Is only slightly different to 2). As Internet bandwidth/capacity improved it became apparent that the server no longer needed to be in the same building. It could reside in a group practice head office, an IT company facility or anywhere that provided Internet connected data storage. Even, potentially in a different state. Practice Staff often connected in the same way, potentially unaware that their database was 100s of KM away. Sometimes a cleverer version of connection was used (VM or virtual Machine for instance), but essentially the GP was still "virtually" sitting in front of the main server. Clever technology meant that even though the server was a long way away, it could still be configured to know what printer you were connected to back at your desk.

A big advantage of this method is that someone outside the practice is fully responsible for backing up and maintaining the server. It is *potentially* a way to save IT support costs. This is what a lot of people are referring to when they talk about being "in the cloud".

Methods 2 or 3 are what most practices are currently at, I would say.

Method 4) this is where programs like Helix and Clinic2Cloud come in. These are CLOUD based APPLICATIONS as opposed to virtual desktops and the visible difference is that you operate these programs with your web browser, e.g. Chrome, Internet Explorer, Edge etc. The advantage of these programs is that basically anywhere you can connect to the internet (phone,pc,tablet) you can access your clinical database.

This is a powerful incentive. The disadvantage of these programs is that their functionality is restricted to what your web browser can do, and this has meant that they still struggle to match all the functionality that clinicians have got used to using their pc/server based versions of MD and BP. Until they can at least match this functionality, once the thrill of the new has worn off, the cloud based version may feel like a backward step.

In this model the program and data are generally hosted on the Software company servers, so they can do all the backups of data, and updates are rolled out by them. Because they are just applications as opposed to whole desktops, practices will still need one of the earlier setups for their other program and data needs.

So, depending on who is talking, the cloud may just refer to having your server at a remote location, or it may refer to using a cloud based clinical program (Helix etc) as well as your clinical data being stored with the software company. I hope this has helped.

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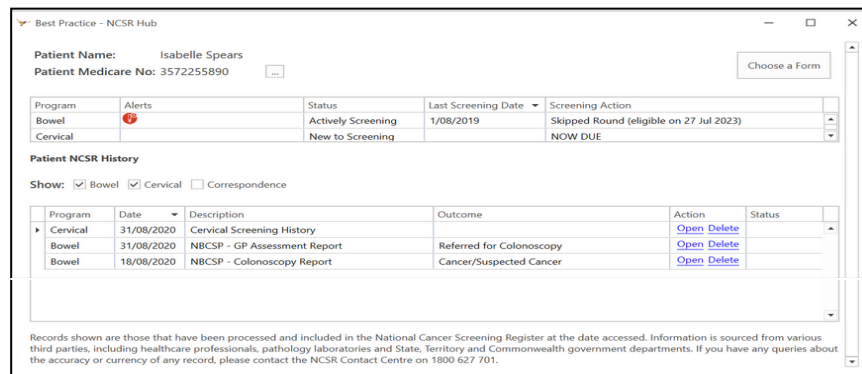
BP

If you work in General Practice you are fortunate to be sitting in front of some of the most usable and functional medical software available in Australia. I have met plenty of clinicians just out of Aged Care or Hospital settings who can attest to that. If your practice runs Best Practice, then, along with approximately 70% of General Practices in Australia you are luckier still, in that you are using what is widely accepted as the premier product.

The core program is clearly very good, but it's the third party additions and optional connections that make the program great. Sometimes these extras are just not enabled or not installed by your IT team. Sometimes a configuration or preference error can be compromising your functionality. So, are you getting the most out of Best Practice? Are you getting the Quarter Pounder® or the Big Mac®?

Allow this big MCK to explain further:

1. National Cancer Screening Registry Integration: If you don't see NCSR Hub under the view menu within a patient record, then your practice hasn't enabled this connection. Admittedly there is a little fiddling in [Proda and some software configuration](#), but as mentioned in my [Feb 2021](#) issue, the effort is well worth it.

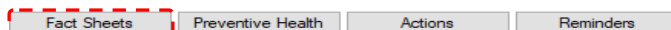


As well as being able to browse Bowel and Cervical screening results and risk factors, you can view correspondence and submit related forms. Once enabled, NCSR reminders will also display in the patient's notification area.



When people are contemplated medical software choices, for me a big consideration is how well does the program interact with other electronic clinical systems. This NCSR integration delivers a very big tick under this criteria. Full functionality information [here](#).

2. Healthshare Fact Sheets:



If you don't see the above button in the patient record, then your IT support have neglected to tick the box under 3rd Party Applications when they have run a BP update or installation. I would ask them to remedy this. If you do see the box but get an error when you click the button, enable the tick box under *Setup..Preferences..General* (bottom of dialogue)

Once enabled you have access to a searchable database of healthshare endorsed Patient Information on the internet. Whilst BP's built in library is very good, these resources can be emailed directly to the patient (using a healthshare email address). Additionally, you can tag favourites so you don't have to search each time.



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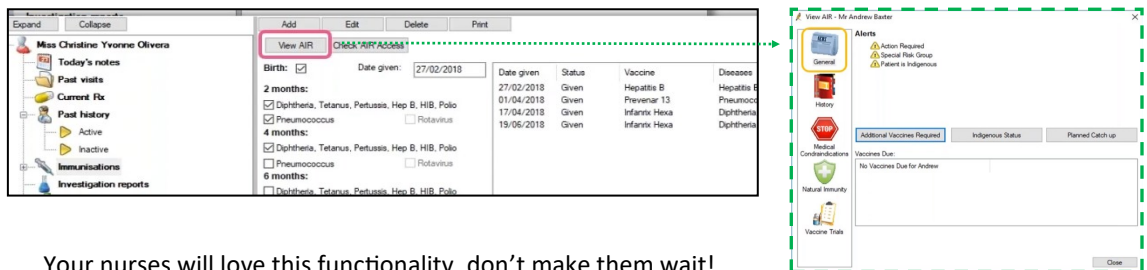
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BP

BP extras continued..


3. Australian Immunisation Register (AIR)

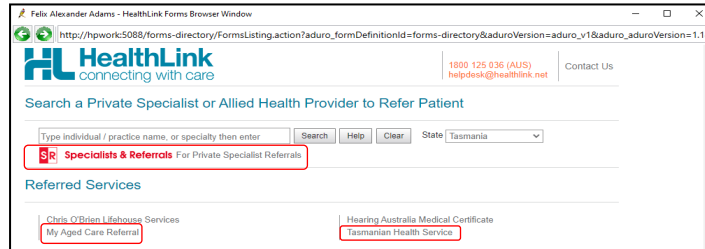
I know it's been mentioned recently, but the AIR browsing as a result of the Saffron SP3 upgrade is a wonderful addition to the software. GPs will have this access automatically as their provider number is used. For your nurses to have access, you need to apply for a Location Provider No (if you haven't already got one) using the [IM-004](#) form and once acquired input the number in *Setup..Practice Details* for each of your locations.



Your nurses will love this functionality, don't make them wait!

4. Electronic THS Referral and MyAgedCare

If you click on this icon  from the patient record, or from within Correspondence Out, you should see the screen below. If you see a Firewall error message, it is a 5 minute job for your IT staff. If you don't see the icon at all, get your practice Manager to enable the Healthlink permission in your user permissions.



This smartforms interface gives you the ability to lodge an electronic My Aged Care form as well as refer electronically to three THS clinics. More clinics have been promised for July (again!) and I'm really hoping that the THS/PHN can deliver on this, as it's probably the biggest barrier to increased uptake. There is also a form based electronic referral mechanism for certain specialists, both here and interstate.

5. MyHR

If the button's greyed out, then either the user has no HPI-I entered or the My Health Record permission hasn't been set. But as you need the HPI-I for ecripts, non-access to this system is going to be a result of user attitude rather than any configuration error. This button is a gateway to dispensing information, [pathology and also THS imaging results](#), discharge summaries and Medicare Billing History. Not to mention the odd Shared Health Summary. Despite all this, there are STILL GPs who studiously look the other way.

6. TopBar

Sneaking this in here as is not a BP specific addon, but a useful thing to be running. Putting clinical data quality prompts aside, the [Flu app](#) mentioned in my [May 2021](#) issue has a really nicely designed display. It seems timely to mention again, reminding you that the app tells you at a glance the patient's vaccination status and funding eligibility.



There is no extra cost to any of these features. Hopefully this inspires users to insist on the full range of functionality being enabled in Best Practice.

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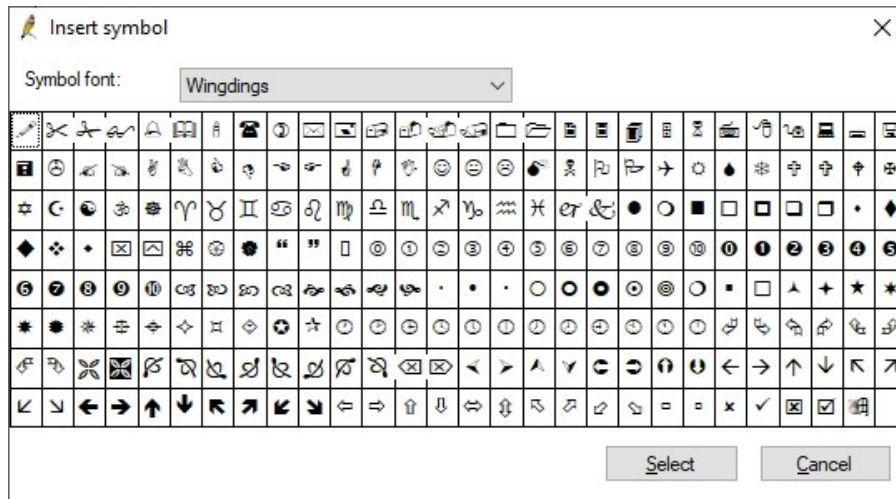
Bits

Sometimes 26 letters and 10 digits just aren't enough. Sometimes we may want to get a bit creative with our documents and include non-regular characters or numbers that aren't just numbers.

A nice easy way is to just select one of the symbol type font sets. For instance if we select wingdings, font the "q" character gives us ☐ and the "x" character gives us ☒. This is a tool I sometimes use when creating a form type template. I use wingdings "q" for an empty check box, and whoever types an x over that character will get an x in a checkbox.

There are hard to memorise key strokes for these types of characters, but happily there are easier ways to fancy up your documents. In the Best Practice word processor, you can go to the *Insert* menu and choose *Symbol*.

Change to a font set like Windings for instance. Click on the symbol you want, click Select and it will be inserted into your document at the cursor point. You can access all sorts of exotic characters with these font sets. The Symbols font will give you access to some of the business symbols like ©



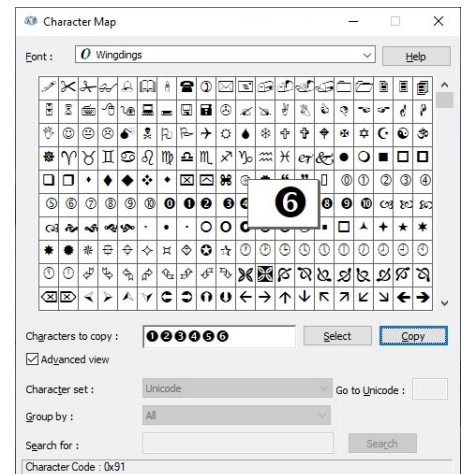
As I write this article, an uneasy feeling of "who actually cares" is starting to intrude on my thoughts, but I brush this aside because MD users need to know that even they cannot access similar functionality through *Letter Writer*, Microsoft Windows makes this available to all via the Character Map App.

So on your windows Taskbar, usually at bottom left of screen, you will see either magnifying glass with or without a space next to it. Type "charmap" next to this, to reveal the application.



Clicking this will bring the screen at right which gives very similar functionality to what is described in the last paragraph. The only real difference is that you can select multiple characters at once and then copy and paste them to your document.

Which is how I did this: ①②③④⑤⑥



So there you go, a way to access those more unusual characters. Now you can stop wondering!