MedicalDirector Training for Clinical Nurses

This is a great opportunity for new nurses and current nurses to update and refresh your skills

Grant Smith

Kylie Goodwin

Barb Repcen

Acknowledgement of Country

Eastern Melbourne PHN acknowledges the Wurundjeri people and other peoples of the Kulin Nation on whose unceded lands our work in the community takes place. We pay our respect to Aboriginal and Torres Strait Islander cultures; and to Elders past and present. EMPHN is committed to the healing of country, working towards equity in health outcomes, and the ongoing journey of reconciliation.

Recognition of lived experience

We recognise and value the knowledge and wisdom of people with lived experience, their supporters and the practitioners who work with them and celebrate their strength and resilience in facing the challenges associated with recovery. We acknowledge the important contribution that they make to the development and delivery of health and community services in our catchment.

Housekeeping

All attendees are muted

Q&A will be at the conclusion of this session

This session is being recorded

Audio:

Listen via your computer's speakers

Telephone Number – within the audio section or access details supplied in registration email

Questions:

Post your questions in the 'Questions' section in the webinar panel or email hello@medicaldirector.com

digitalhealth@emphn.org.au

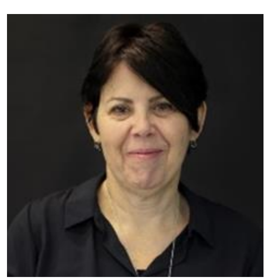
Agenda

SPEAKERS:

Grant Smith,
Practice Consultant

MedicalDirector | Telstra Health

Kylie Goodwin,
Practice Consultant
MedicalDirector | Telstra Health



Barb Repcen,
Program Specialist- Digital Health

EMPHN

AGENDA:

- 4.3 New Enhancements
- Recording measures
- Recording Immunisations
- Recording Cervical Screening
- Managing Recalls and recording contact
- Recording social and family history including recording alcohol and smoking
- Keeping past history items relevant
- Creating letters
- Data Quality and Data Cleansing
- User Preferences
- My Health Record accessing & uploading

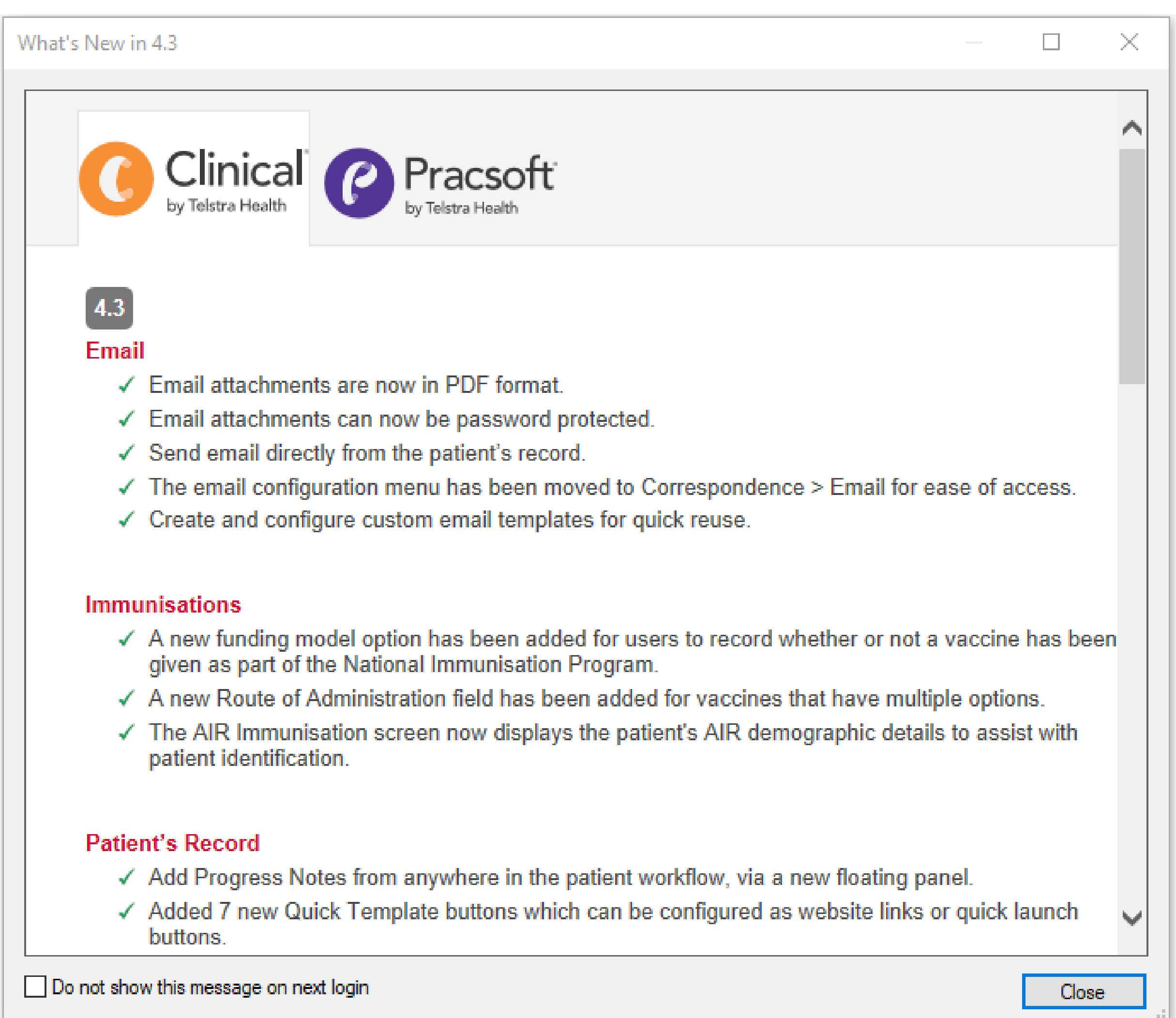
4.3 New Enhancements

Immunisations

- A new funding model option has been added for users to record whether or not a vaccine has been given as part of the National Immunisation Program
- A new Route of Administration field has been added for vaccines that have multiple options
- The AIR Immunisation screen now displays the patient's AIR demographic details to assist with patient identification

Patient's Record

- Add Progress Notes from anywhere in the patient workflow, via a new floating panel
- Added 7 new Quick Template buttons which can be configured as website links or quick launch buttons
- Keyboard shortcuts are now highlighted with an underscore, and new shortcuts have been added
- Added the option to record "No Next of Kin or Emergency Contact Provided" in the patient's record
- Updated ABS Ethnicity to the 2019 Australian Standard Classification of Cultural and Ethnic Groups



Recording Immunisations

Summary | Current Rx | Progress | Past history | Results | Letters | Documents | Old scripts | Imm. | Correspondence | MDExchange | SAT | HealthLink

AIR Web Services

AIR Patient Verification Check

Patient successfully verified with AIR

Notifications

Patient has a Medical Contraindication
Patient has a Natural Immunity
Patient has a Vaccine Trial
Catch-up date period has expired.

☑ Indigenous Status
☐ Special Risk Group

Record Medical Exemption

Record Planned Catch Up

Planned Catch Up 09/09/2022

Download Immunisation Statement

Verified AIR Patient

First Name: KOBY
Surname: EDWARDS
Date of Birth: 17/04/2012
Medicare No: 2953 70105 1
Medicare IRN: 2
Locality: MERRYLANDS
Postcode: 2160

Website | Feedback | Help

Practice Immunisations | Immunisation History | Medical Exemptions | Vaccine Trial History

Date	Immunisation	Sequence	Batc	Vaccine serial number	Consent	Provided by	Vaccinator	Site	Comment	Send to AIR Status
6/09/2023	FLUQUADRI	4	1...		Consentec	Parent	Dr Gavin Donnelly	Buttock I...		Transmitted
4/09/2023	BOOSTRIX						Given elsewhere			
4/09/2023	LIQUID PEDVAXHIB	1	1...		Consentec	Parent	Dr Gavin Donnelly	Deltoid S...		
8/08/2023	JESPECT	1	1				Given elsewhere			Downloaded
8/08/2023	JESPECT	1	1				Given elsewhere			Downloaded
30/06/2023	FLUAD QUAD	1			Consentec	Parent	Dr Gavin Donnelly	Buttock ...		Transmitted
11/04/2023	MENINGITEC	9	1	123			Given elsewhere			Downloaded
11/03/2023	MENINGITEC	7	1	123			Given elsewhere			Downloaded
11/03/2023	MENINGITEC	7	1	123			Given elsewhere			Downloaded
7/03/2023	MENINGITEC	5	1	123			Given elsewhere			Downloaded
6/03/2023	AFLURIA QUAD (NIP	16	1	123			Given elsewhere			Downloaded
16/02/2023	HAVRIX JUNIOR	1	1				Given elsewhere			Downloaded
1/02/2023	MENINGITEC	6	1	123			Given elsewhere			Downloaded
1/02/2023	MENINGITEC	4	1	123			Given elsewhere			Downloaded
10/01/2023		15	IN...				Given elsewhere			Downloaded
21/12/2022	PFIZER COMIRNATY	3	123				Given elsewhere			Downloaded
19/12/2022		14	136				Given elsewhere			Downloaded
19/12/2022	H-B-VAX II(ADULT)	1	1...				Given elsewhere			Downloaded
29/11/2022	DUKORAL	3	S...				Given elsewhere			Downloaded
28/11/2022	DUKORAL	3	S...				Given elsewhere			Downloaded
20/10/2022		13					Given elsewhere			Downloaded
20/10/2022	NIMENRIX						Given elsewhere			Downloaded
14/10/2022	ACAM2000	1	A...				Given elsewhere			Downloaded
10/10/2022		13	N...				Given elsewhere			Downloaded
10/10/2022		12	N...				Given elsewhere			Downloaded

AIR Patient Verification Check

Conduct a live patient verification check with AIR.

Record Medical Exemption

Click to record a medical exemption for the given patient.

Record Planned Catch Up

Click to record a planned catch up for the given patient.

Download Immunisation Statement

Click to download the patient's immunisation statement from AIR.

Recording Immunisations

To Record an Immunisation

1. From the patient's Clinical Window, select the **Imm.** tab.

2. Then, to add an immunisation record, either

○ Click ✚, on the toolbar

○ Press the **F3** key

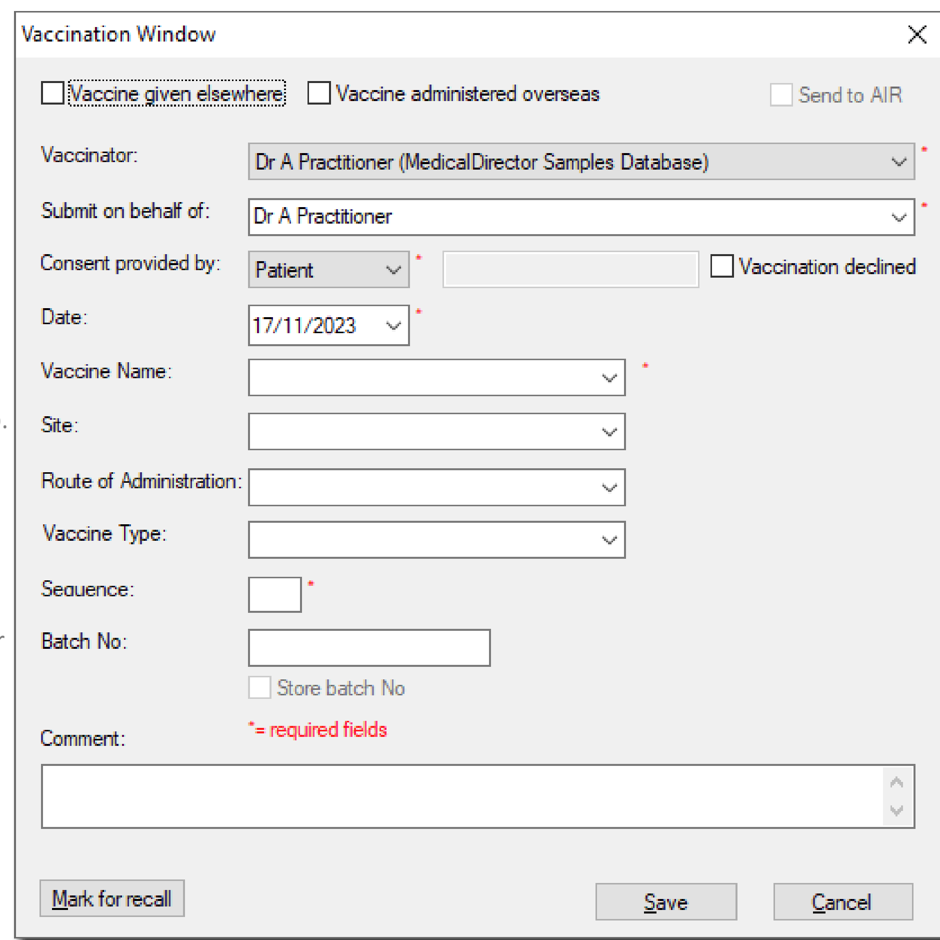
○ Right-click in the list of immunisations (even if list is empty) and select **Record Encounter** from the pop-up menu

3. The **Vaccination** window appears.

○ Indicate whether the vaccine was administered elsewhere (Optional). This sets the Vaccinator drop-down list to 'Given Elsewhere'. The 'Vaccinator' and 'Consent provided by' fields remain disabled.

○ Indicate whether you wish to forward this vaccination data to AIR. The **Send to AIR** check box will be ticked by default, if the following rules are met;

- Applies to any vaccine administered to a patient, that is approved for transmission by AIR.
- The vaccine must be administered at the surgery (i.e. not 'declined' or 'given elsewhere').
- MedicalDirector Clinical must be configured for sending vaccination data to your billing package, and;
- If you are **linked to Pracsoft**, you must also tick the 'Create Immunisations' check box, located in Links Options.
- If you are **linked to a third-party** billing package, you must also;



1 tick the 'Send details of immunisations recorded...' check box in Advanced Link Options.

2 Indicate the output path location for the vaccination data your billing package will read, also located in Advanced Link Options.

○ Select the vaccinator from the drop-down list.

○ Indicate who gave consent for the vaccination.

○ Enter a date on which the immunisation was administered.

○ Select the immunisation name from the list provided.

○ Select the site at which the vaccination was administered.

○ Indicate the route of administration.

○ Indicate the Type of vaccine from the list provided.

○ Enter the Sequence, Batch Number and any comments (if necessary). Note that in the example above we have enforced AIR batch number validation (via Advanced Link Options) and therefore batch numbers must contain only alpha-numeric characters (no spaces or punctuation).

○ (Optional) Click Mark for recall button to generate a recall notification to have the patient recalled for another immunisation in the future. ERROR: Variable (Recall_Management) is undefined.

4. Click Save button to save the immunisation record and return to the patient's record.

Recording Immunisations

To determine if a patient requires one or more vaccinations according to the National Immunisation Program Schedule, consult the Due Vaccines list on the Immunisation History tab. This list is generated in real time from the Australian Immunisations Register.

See Recording Immunisations for more information.

The Immunisations History tab displays the patient's immunisations history as recorded with the Australian Immunisation Register (AIR). History can include immunisations recorded at your practice, along with those recorded elsewhere.

- **Red** records indicate that some action is required.
- **Black** records are editable. Only immunisations administered at your practice are editable.
- **Blue** entries are those recorded with AIR, and are not editable.

Practice Immunisations | Immunisation History | Medical Exemptions | Vaccine Trial History

Due Vaccines

Disease	Dose	Due Date
Tetanus	2	05/01/2022
Diphtheria	2	05/01/2022
Pertussis	2	05/01/2022
Varicella	1	27/07/2019
Meningococcal ACWY	1	27/01/2019
Mumps	1	27/01/2019

Immunisation History

Date	Vaccine/Brand	Dose	Status	Reason Code	Message
05/11/2021	AFLURIA QUAD	1	VALID		
05/11/2021	ADACEL	1	VALID		

Red - Action Required   Black - Editable   Blue - Not Editable

Patient has a Natural Immunity
Catch-up date period has expired.

Special Risk Group

Record Medical Exemption

Record Planned Catch Up

Planned Catch Up 10/12/2020

Download Immunisation Statement

Verified AIR Patient

First Name: GABRIEL
Surname: BAKER
Date of Birth: 08/03/2002
Medicare No: 2953 63723 1

Immunisation History

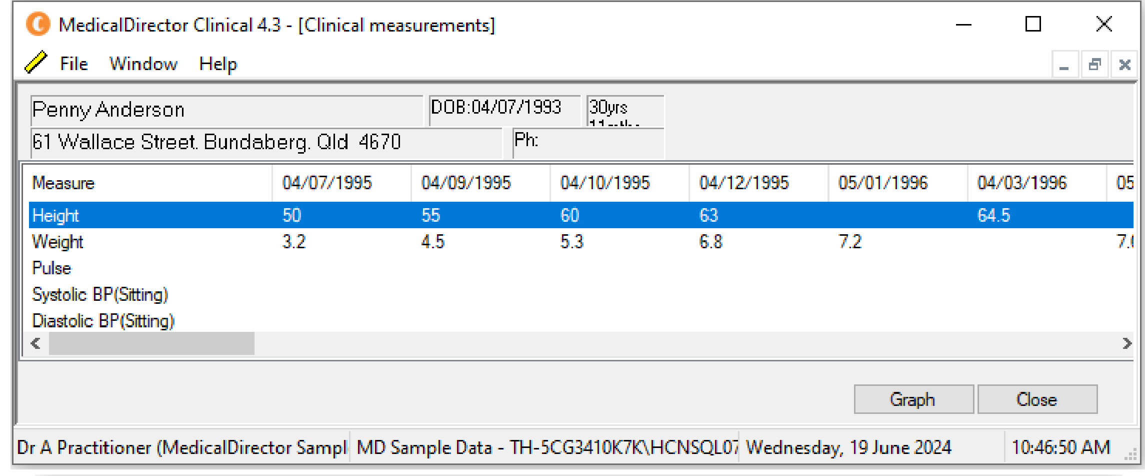
Date	Vaccine/Brand	Dose
27/08/2023	MODERNA SPIKEVAX BIV BA.4-5	V
27/07/2023	DTPA	V
27/07/2	A (NIP)	V
27/07/2		4
27/07/2		V
09/06/2023	MODERNA SPIKEVAX	V
09/06/2023	AFLURIA QUAD (NIP)	V
13/01/2023	ASTRAZENECA VAXZEVRIA	V
11/01/2023	PFIZER COMIRNATY	V

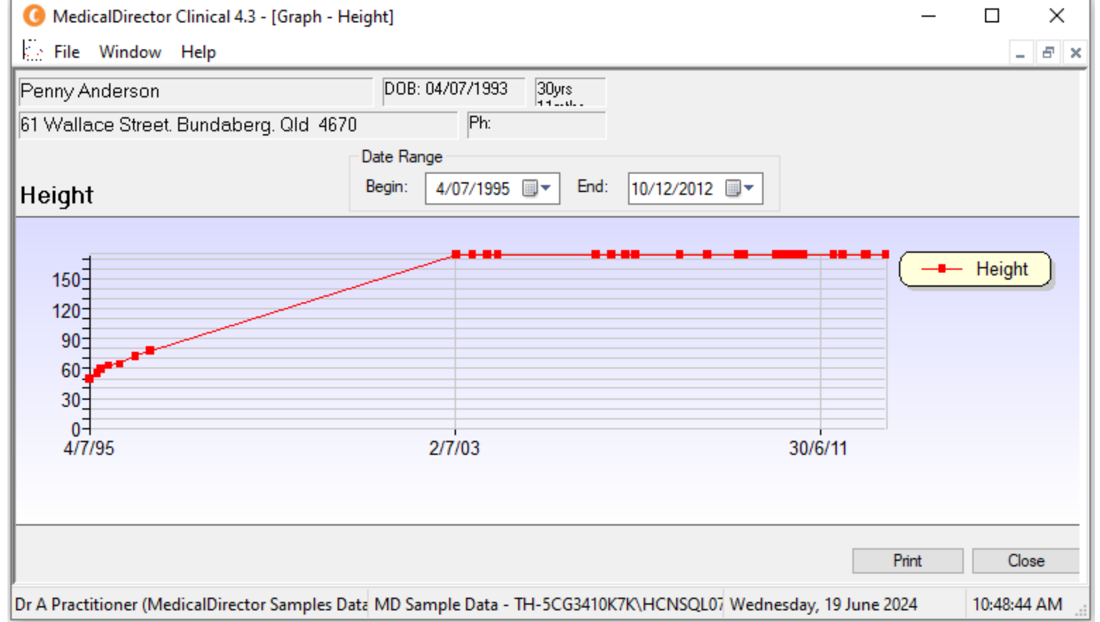
Update Encounter
Refresh
Store Locally

Updating Encounters with AIR

1. Select the **Immunisations History** tab.
2. Locate the record you wish to update with AIR.
3. Right-click the record and select **Update Encounter**.

Recording Measurements





The Clinical Measurements window displays the progress of a patient's various clinical measurements. Measurement data is entered via Progress Notes and various Tools.

To view clinical measurements select **Clinical > Measurements** from with a patient's Clinical Window

- Measurements are listed on the left side of the window and separated into the various sections, including BMI, CVRISK, PEFR, SYSTOLIC, DIASTOLIC, for example.
- Measurement recording dates appear as column headings.
- To view specific measurements in graph form, select an entry and click **Graph**

Recording Measurements

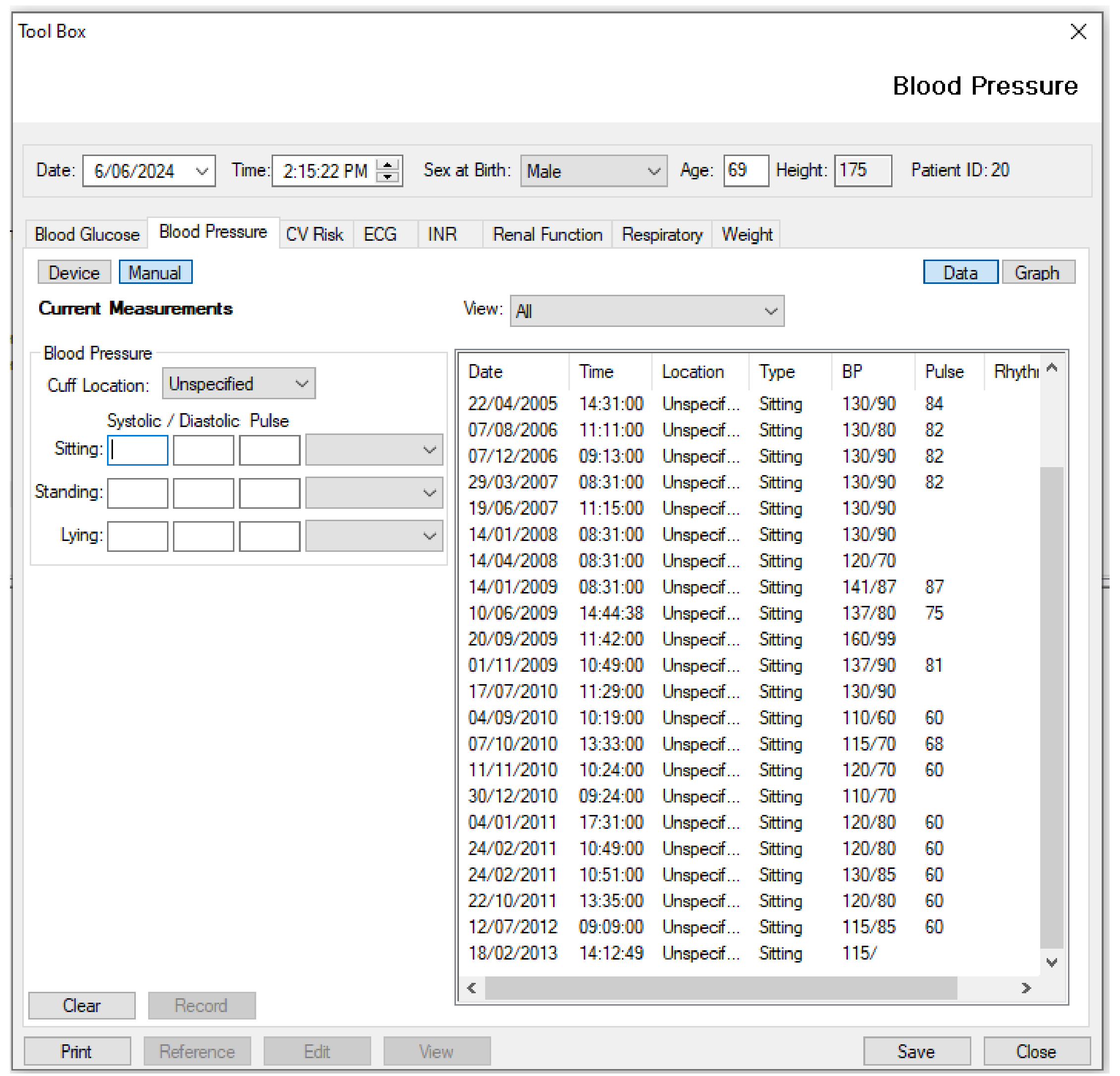
The Tool Box is a suite of tools for recording patient readings, either calculated manually or via a Diagnostic Devices, with each tool provided on a separate tab as shown in the following image.

The upper section of this window provides a means to;

- Mark the date and time on which the recordings were taken, and
- Test the tools using fictitious data (Sex at Birth and Age). Note that although you can change the patient's sex at birth and age here, these changes are not saved back to their record.

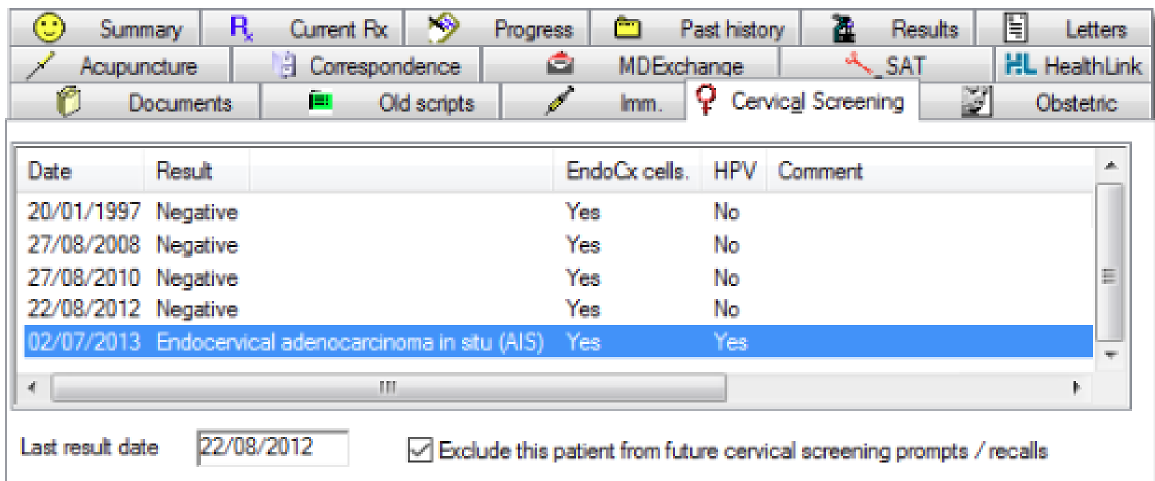
The lower section displays a selection of tool tabs. Some tabs require that you enter general data before recordings can be made. You will be prompted accordingly when this is necessary.

Blood Glucose
Blood Pressure
Cardiovascular Risk - Absolute Calculator
Cardiovascular Risk - Relative Calculator
Electrocardiogram
INR Record
Paediatric Percentile Charts
Renal Function Calculator
Respiratory Function
Weight



Recording Cervical Screening via the Patient's Record

1. Select the Cervical Screening tab in the patient's clinical record.

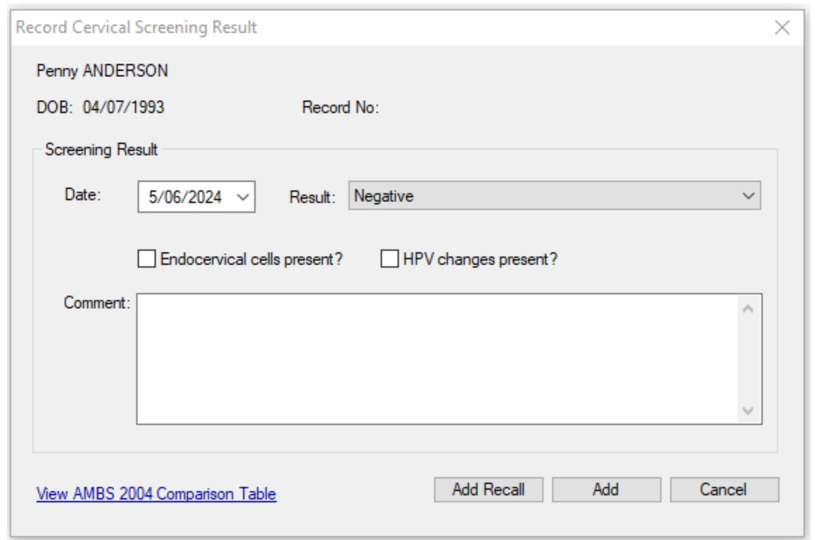


2. Either,

- Click ✚
- Press **F3**
- Right-click within the list of recorded screens and select **New Item** from the menu that appears

3. The **Record Cervical Screening Result** window appears.

- Enter the date on which the screen was obtained from the patient.
- Select a result type from the list provided.
- Tick check boxes as appropriate to indicate whether Endocervical cells and/or H.P.V. changes were present.
- If you wish to generate a Recall notification for this patient, click **Add Recall**



4. Click **Add** to confirm and save your data.

Recording Cervical Screening via the Holding File

1. Select **Correspondence > Check Holding File** to open the Holding File.

2. From this window select which recipient will request the Cervical Screening.

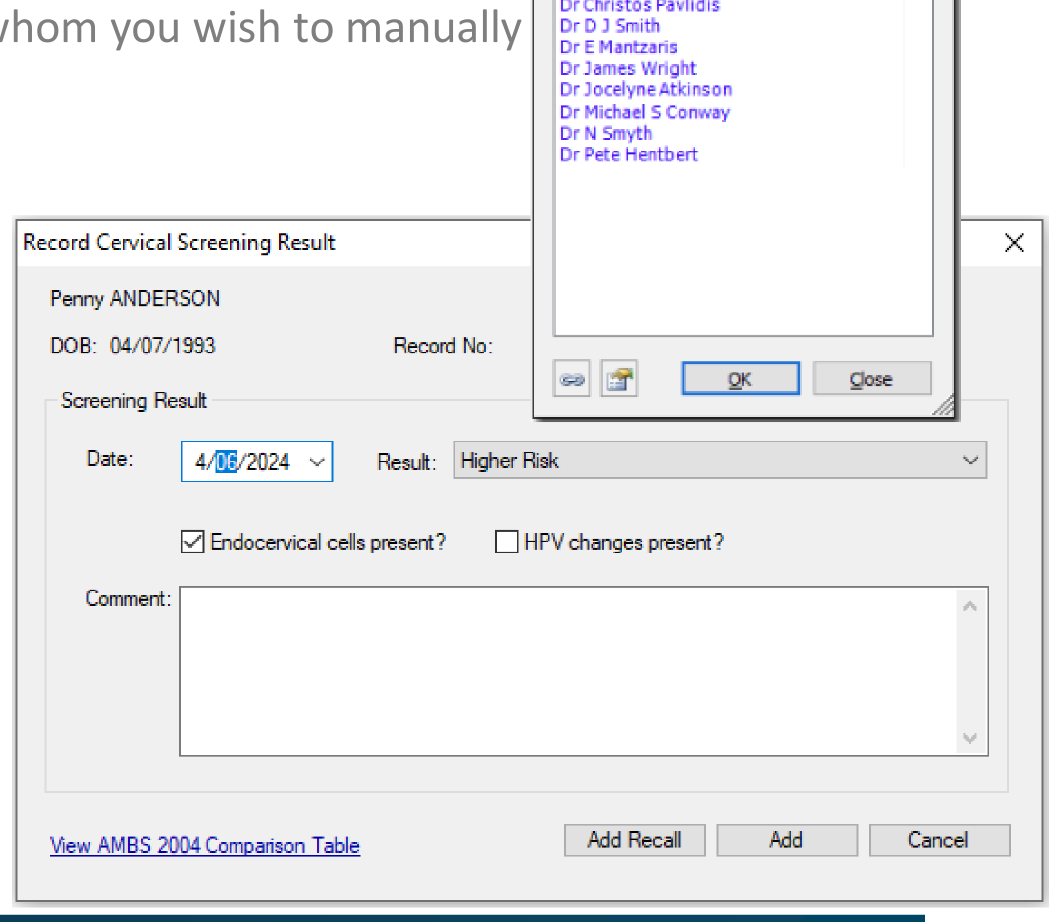
3. Once within the Holding File, locate and select the patient for whom you wish to manually record a cervical screening.

4. Then, select **File > Add Cervical Screening Result**.

The **Record Cervical Screening Result** window appears.

- Enter the date on which the screen was obtained from the patient.
- Select a result type from the list provided.
- Tick check boxes as appropriate to indicate whether Endocervical cells and/or H.P.V. changes were present.
- If you wish to generate a Recall notification for this patient, click **Add Recall**

5. Click **Add** to confirm and save your data. The result is added to the Cervical Screening tab of the patient's record.

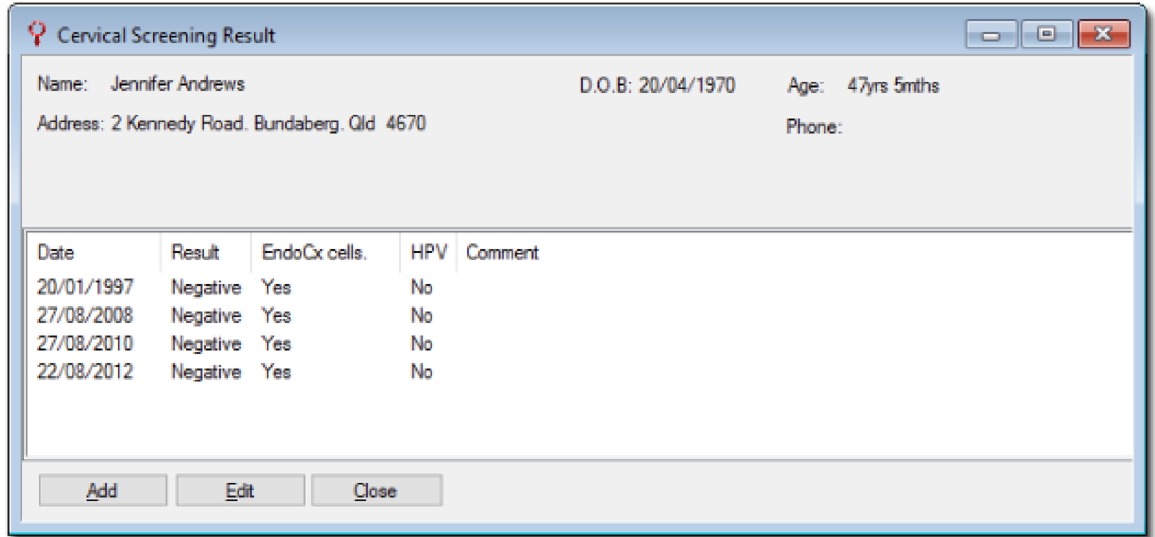


Recording Cervical Screening via the Clinical Front Screen

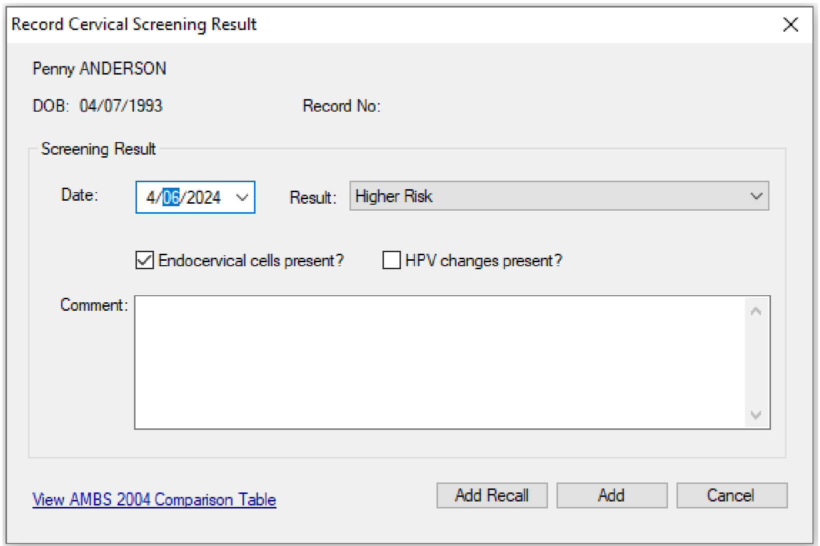
1. From the Clinical Front Screen, select **Clinical > Cervical Screen Results > Add Result**. The **Select Patient from List** window appears.

2. Search for and open the patient record you want to add a result for. The Cervical Screening Result summary for the patient will appear.

- Only female or gender-neutral patients will appear in the list.



3. Click **Add** The **Record Cervical Screening Result** window appears.
   - Enter the date on which the screen was obtained from the patient.
   - Select a result type from the list provided.
   - Tick check boxes as appropriate to indicate whether Endocervical cells and/or H.P.V. changes were present.
   - If you wish to generate a Recall notification for this patient, click **Add Recall**



4. Click **Add** to confirm and save your data.

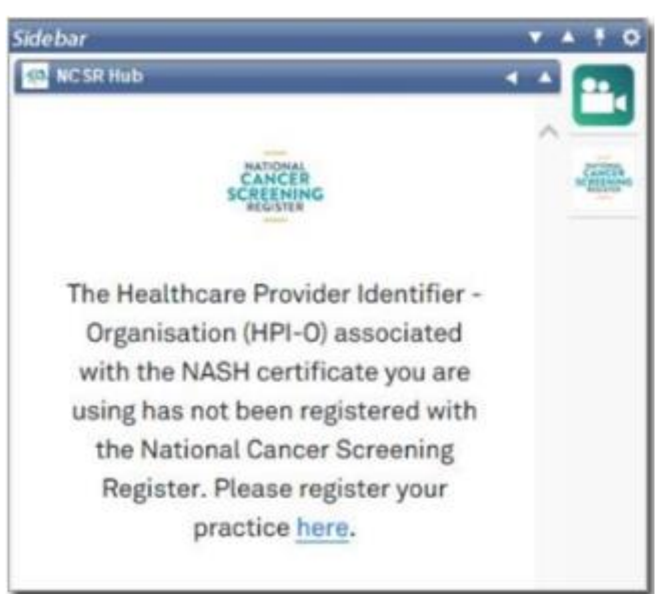
National Cancer Screening Register

The National Cancer Screening Register enables a single electronic record for each person in Australia participating in cervical and bowel screening. The National Cancer Screening Register plays a vital role in supporting the National Cervical Screening Program (NCSP) and the National Bowel Cancer Screening Program (NBCSP). It gives healthcare providers access to their patients' health information and makes it easier for program participants to take control of their health.

Healthcare providers that have integrated their Clinical Information System with the National Cancer Screening Register, are able to interact directly with the National Cancer Screening Register from their existing software using the NCSR widget.

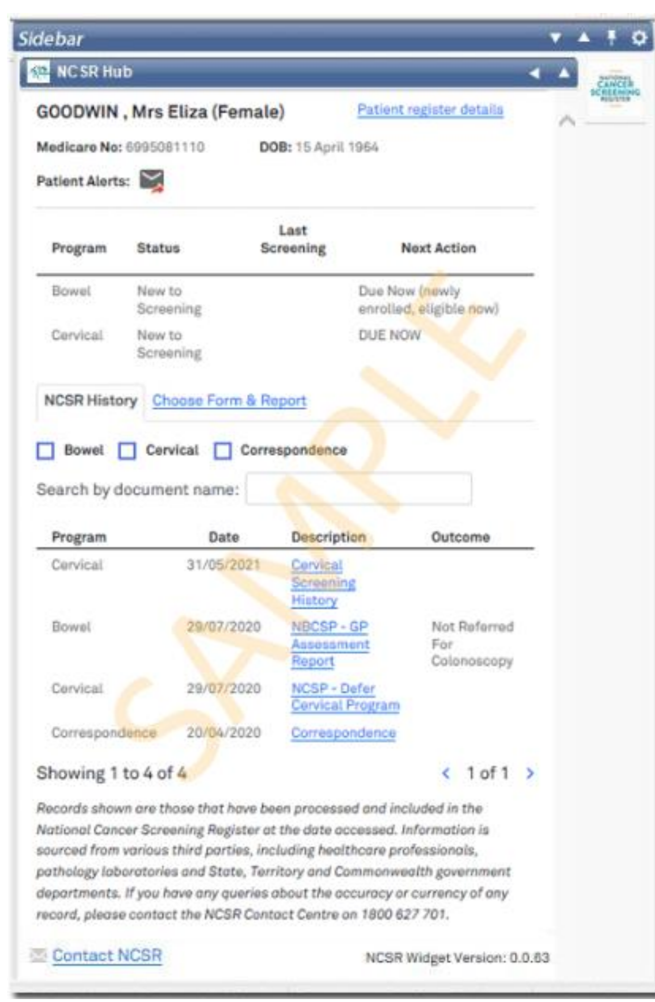
This enables the user to:

•Open the patient's record and view their test results, summary of the outcome and screening histories;
•View the patient's screening status and alerts;
•View the patient's next screening eligible date;
•Generate cervical screening history report;
•Submit Program forms to the Register – cervical and bowel screening program forms;
•View and update the patient's demographic details;
•Manage the patient's screening participation, including opting out, resuming participation or deferring from either the bowel or cervical screening programs;
•Cease the patient's correspondence for the cervical screening program; and
•Nominate other people to assist your patient (such as a personal representative or another Healthcare Provider).
For further assistance, you can call the contact centre on 1800 627 701. The contact centre operates Monday to Friday, between 8am and 6pm in all Australian state and territory time zones.

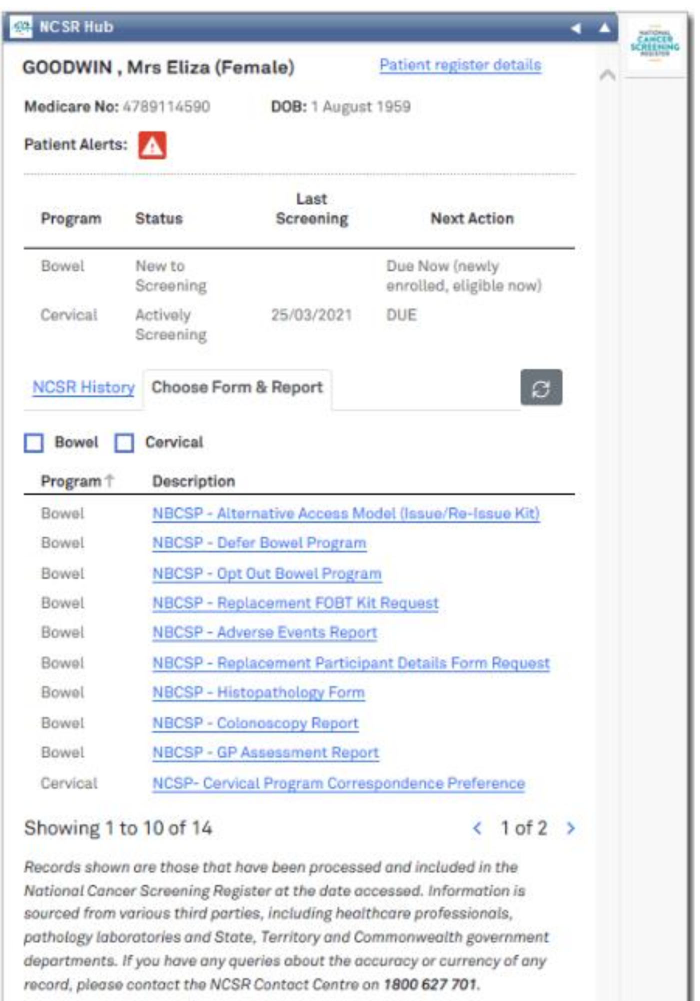


National Cancer Screening Register – Bowel & Cervical Screening

1. For registered patients, the widget appears as follows with the NCSR History tab presented by default. This tab contains the patient's history of screening results retained within the National Cancer Screening Register.



2. Switch to the **Choose Form & Report** tab to select a form/report to submit.



National Cancer Screening Register – Bowel & Cervical Screening

3. Complete and submit the form.

NCSR Hub -- Webpage Dialog

Bowel - NBCSP - Colonoscopy Report

GOODWIN , Mrs Eliza (Female)

Date of Birth	Age	Medicare Number	Address
15 April 1964	57	6995081110	110, Bundaberg

Australian Government

NATIONAL CANCER SCREENING REGISTER

Patient details/ Referring GP | Sedation | Colonoscopy

Patient Details

Does the patient identify as Aboriginal or Torres Strait Islander origin? (If known)
- Aboriginal
- Torres Strait Islander
- Aboriginal and Torres Strait Islander
- Non Indigenous
- Prefer not to answer

What is the patient's Country of Origin? (if known)

What is the patient's preferred language spoken at home? (If known)

Was this a public or private patient?
- Private patient
- Public patient

Referring general practitioner

Doctor's Provider number lookup

Or tick here to manually enter provider details

Submit Form

Managing Recalls – Sample workflow by Katrina Otto

A Recall is a patient's reminder notice to inform the patient that they are due to return to the Practice (usually so that some clinical procedure can be performed).

The Search Recalls module allows you to;

- Determine which patients are to be recalled i.e. those with current Recalls.
- Indicate that the results should include completed and/or deleted Recalls.
- Determine which patients you have already attempted to contact regarding their Recall(s).
- Record notes against Recalls. See Recall Actions for more information about these notes.
- Save your favourite Recall notification search lists.
- Print labels or conduct a mail merge for contacting patients.
- Send e-mail Recall notifications.
- Send SMS Recall notifications.
- Mark recalls as being completed, and optionally update recurring recalls.

MEDICALDIRECTOR – RECALL MANAGEMENT PROTOCOL – SAMPLE 2

Train IT Medical
Competence with Confidence

DOCTOR ADDS RECALL to PATIENT FILE
(Tick 'Return Urgently' for Clinically Significant Items)

If RECALL is marked 'RETURN URGENTLY'

↓ **Admin Staff to generate list of URGENT RECALLS daily**

↓ Admin staff: Generate list and phone or SMS patients for follow up visit/appointment due within 1 week. Record contact attempt against Recall in MD and add comments. DO NOT Update recall when prompted.

↓ Admin staff: Generate list of all URGENT recalls that are overdue and have 1 contact attempt. Phone all patients on the list and record as second contact attempt.

↓ Admin staff: Generate list of all URGENT recalls that are overdue and have 2 contact attempts. Mail merge urgent letter and record as 3rd contact attempt.

If RECALL is not marked RETURN URGENTLY

↓ **Admin staff to generate a list of all NON URGENT recalls weekly due within next fortnight**

SMS

↓ Record contact attempt against recall in MD (Send SMS)

↓ Admin staff – send SMS to patients with mobile phone details recorded. DO NOT update recall

↓ Record 2nd contact attempt (send SMS) and Send 2nd SMS to patients with 1 contact attempt recorded against recalls that are overdue.

Letter

↓ Record contact attempt against recall in MD (Send Letter)

↓ Admin staff –Mail Merge / send letter to patients with no mobile phone details recorded. Do not update recall

↓ Record 2nd contact attempt (send letter) and Send 2nd letter to patients with 1 contact attempt recorded against recalls that are overdue.

↓ **Doctor updates/completes recall (Open patient > Recall button>Update) once patient returns and marks outstanding correspondence/result as 'notified' if relevant when patient returns.**

www.trainitmedical.com.au   Sample flowchart to be used as a team worksheet to assist in the design of suitable individual practice protocols

Managing Recalls – via the Search > Recall window

A Recall is a patient's reminder notice to inform the patient that they are due to return to the Practice (usually so that some clinical procedure can be performed).

The Search Recalls module allows you to;

- Determine which patients are to be recalled i.e. those with current Recalls.
- Indicate that the results should include completed and/or deleted Recalls.
- Determine which patients you have already attempted to contact regarding their Recall(s).
- Record notes against Recalls. See Recall Actions for more information about these notes.
- Save your favourite Recall notification search lists.
- Print labels or conduct a mail merge for contacting patients.
- Send e-mail Recall notifications.
- Send SMS Recall notifications.
- Mark recalls as being completed, and optionally update recurring recalls.

Recall Search Criteria

Recall Reasons: 3 of 19 selected

☐ Show only reasons from active recalls

☐ All Reasons

BLOOD PRESSURE REVIEW
BLOOD TEST
DIABETES REVIEW
GENERAL CHECK-UP
GENERAL CHECKUP
IMMUNISATION
IMMUNISATION - 10 YEAR
IMMUNISATION - 12 MONTH
IMMUNISATION - 18 MONTH
IMMUNISATION - 2 YEAR
IMMUNISATION - 4 MONTH
IMMUNISATION - 4 YEAR
IMMUNISATION - 6 MONTH

Assigned To: All Users

☐ Show only users with active recalls

☑ All Users ☐ Show 'Unknown' User

Name	Status
Dr A Practitioner	Active
Registered Nurse	Active

Search > Recall (via the front screen)

☐ Include inactive patients

Status

☐ Include deleted recalls ☐ Include completed recalls

Patient Contact

☐ Attempted to contact patient at least

☐ Only show patients that have attended in response to a recall

Date Range

All Start: End:

Saved Searches

Default Search	Search Name
☑	My search criteria
☐	Blood tests
☐	Diabetes review for Dr A Practitioner

Load Save Rename Delete

Search Cancel

Managing Recalls - via the Search > Recalls window

Conducting a Search for Recalls

1. From the Clinical main screen, select **Search > Recall**.
2. MedicalDirector Clinical's list of Recalls opens, and you are automatically prompted to select criteria for conducting a search of upcoming recalls, using the **Recall Search Criteria** window. See the table below for information on key features of this window.
3. Enter the criteria you wish to search for. Click **Search** button when you are ready to conduct the search.
4. The Search Recalls list becomes populated with your search results. Consult the table below for features of this window.

Show only reasons from active recalls	Tick this check box to filter the Recall Reasons list to display only reasons associated with active recalls. An 'active' recall is one that is neither completed, nor deleted. Note that enabling this check box has no impact on the search results themselves, but is provided here only for the convenience of filtering the selection list.
Attempted to contact patient at least...	When recording an Action against a Recall, you can indicate that the Action was an attempt to contact the patient about their Recall. You can instruct the Recall search module to show only those Recalls where [x] attempts to contact the patient have been made.
Only show patients that have attended...	For use at sites that run MedicalDirector Pracsoft in conjunction with Clinical. MedicalDirector Pracsoft provides a facility for indicating that a patient is returning to your practice in response to a specific Recall. By ticking this associated check box, you can instruct the Recall search module to show only those patients that have been flagged in this way.
Date Range	Allows you to specify when the recalls are due. Note that this date is not when the Recalls were created.
Saved Searches	Your search criteria can be saved. See Saving Recall Searches for more information.
Include Inactive Patients	Allows you to search for patients flagged as inactive.

Managing Recalls - via the Search > Recalls window > Upper Section

Upper Section

The upper section of this widow displays all the Recalls that match your search criteria.

- **Black entries are active (current) Recalls**
- Grey entries are deleted Recalls
- Blue entries are completed Recalls

Select All / Select None	A toggle button for selecting all records, or none.
Search	Click to call the search criteria window.
Search > Save Current Search Criteria Save Recall Search Recall search name: Diabetes Review for Dr A Practitioner Set as my default search OK Cancel	Allows you to save the criteria used to conduct the search. You will be prompted to name the search. Afterwards, this search will be available from the 'Saved Searches' section of the **Recall Search Criteria** window. See Saving Recall Searches for more information.
Refresh	Refreshes the window with the latest data.
Add Recall	Select a patient from the list of search results, and then click this button to record a new Recall for the patient.
Add Recall > Delete Recall	Deletes the selected Recall.
Open Patient	Opens the record of the selected patient.

Managing Recalls - via the Search > Recalls window > Upper Section

Export

Export Recall Search Results

Export Scope
- Export All Rows
- Export Highlighted Rows
- Include Hidden Columns
- Include Column Headers

Export Format
- Comma Delimited CSV
- Pipe Delimited CSV
- Tab Delimited CSV

Export Format
Folder: C:\My Recall Searches
File Name: RecallSearch_20161118_132929.csv

OK | Cancel

Allows you to export the list of search results.

Mail Merge

Mail Merge Options

Mail Merge Scope
- All Recalls
- Selected Recalls

Print Options
- Print labels after the mail merge.

For patients who have multiple, different recalls due, you can choose to either;

- Separate each recall reason, printing a letter for each one, or
- Collate all recall reasons into a single letter.

If you choose to collate reasons, the date of the earliest recall in the set is used for the letter.

Collated | Separated | Cancel

Allows you to bulk-print a letter for the selected records. See also Labels.

After conducting a mail merge, you will be prompted to update (complete) the recalls.

Mail Merge > Print Labels

Print ...

Print Labels Scope
- All Recalls
- Selected Recalls

Continue | Cancel

Allows you to bulk-print address labels for the selected records. See also Labels.

Managing Recalls - via the Search > Recalls window > Upper Section

Print List	Prints the list of selected recalls to the printer you have selected as your Letter Writer printer. After printing the list, you will be prompted to update (complete) the recalls.
Print List > Print List To	Print the list of selected recalls (allows you to select a printer first). After printing the list, you will be prompted to update (complete) the recalls.
Update	Allows you to update (mark as 'complete) any selected recalls. See Completing (Updating) Recalls.
Send SMS	Allows you to send an SMS reminder to the selected patients, regarding their selected Recalls i.e. if a given patient has three Recalls upcoming, they will receive three SMS messages - one for each Recall. SMS messages sent from the Search Recalls window will use the 'Recall' SMS template. After sending an SMS, you will be prompted to update (complete) the recalls.
Clear Filters	Clears all filters you have applied to the search results. If you wish to clear an individual filter, click the **Remove Filter** button, located within each filter window (accessed by clicking).
Reset Window Settings	Resets the layout of this window to its defaults.

Managing Recalls - via the Search > Recalls window > Lower Section

Lower Section

The lower section (known as the Actions Pane) is split into two panels;

•The lower left-hand panel lists all the Actions taken upon the Recall selected in the upper section. In the example above we have selected a Recall for Carolina Schein in the upper section, and in the Actions Pane we can see the three Actions that have been performed against that particular Recall.

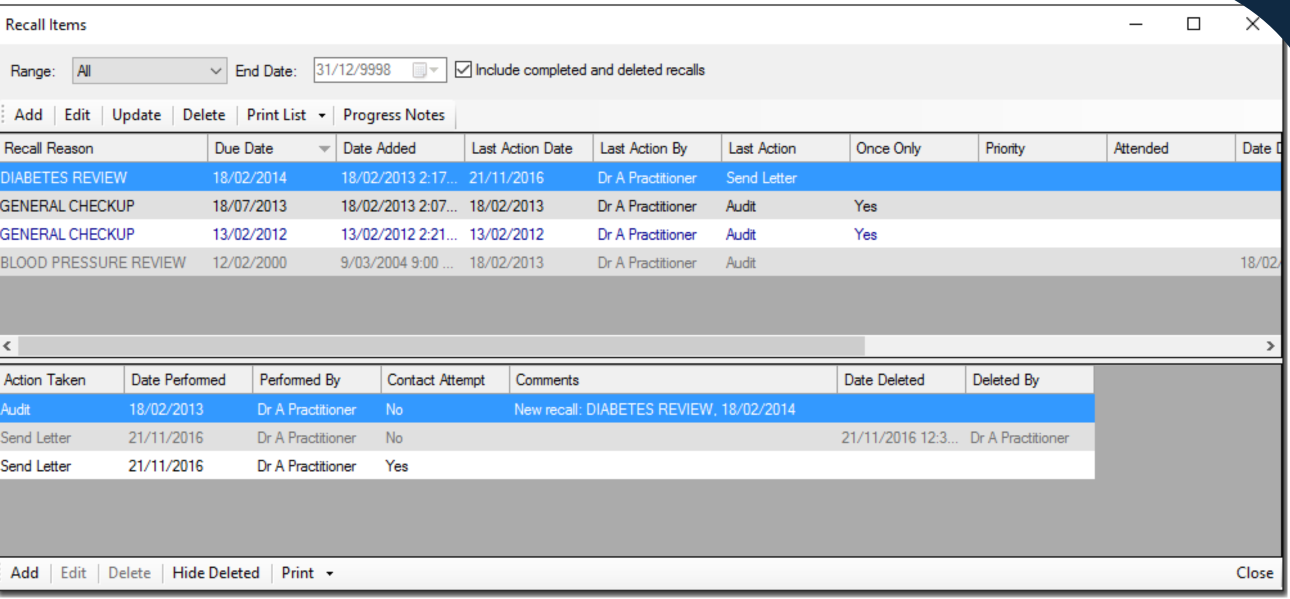
•The lower right-hand panel (known as the Details Panel) displays the basic demographics of the selected patient.

Action Taken	Displays the type of Action recorded against the Recall selected in the search results.
Date Performed	The date on which the associated Action was recorded.
Performed By	The user that recorded the associated Action.
Contact Attempt	Whether the selected action was an attempt to contact the patient.
Comments	Any comments recorded against the Action performed. Comments can be made about a Recall Action at the time you add one.
Date Deleted	The date on which a given Action was deleted.
Deleted By	The user that deleted the Action.
Print	Prints the Actions performed against a selected Recall to the printer you have selected as your Letter Writer printer.
Print > Print To...	Prints the Actions performed against a selected Recall. Allows you to select the printer to print to.

Managing Recalls - via the Search > Recalls window > Lower Section

Add	Allows you to record a new Recall Action for the selected Recall.
Edit	Allows you to edit a selected Action.
Delete	Deletes the selected Action.
Show Deleted / Hide Deleted	A toggle to show/hide deleted actions.
Hide Actions Pane	A toggle button for hiding/showing the Actions Pane. This button is only available if the lower half of this window is visible. See 'Hide Details' in this table for more information.
Hide Details Panel	A toggle button for hiding/showing the Details Panel located in the right-hand section of the Actions Pane.
Close	Closes the Search Recalls module

Managing Recalls - via the Patient's Record



1. Select **Clinical > Recall**. The **Recall Items** window appears.

- The upper section of this window lists the patient's recalls.
- The lower section lists any recalls actions you have recorded against each of the recalls in the upper section i.e. each recall can have multiple actions recorded against it.

2. Select one of the available recalls in the upper section to manage actions for.

3. (optional) If the selected recall has had actions applied to it which were subsequently deleted, you can reveal these now by clicking the **Show Deleted** button. If this button is not available, it is because there a no deleted actions to reveal.

4. Then to;

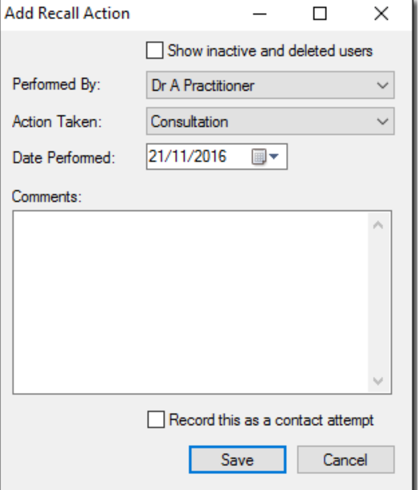
- **Add** a new action, click **Add**. Continue now to Step 5.
- **Edit** an existing action, select it from those available, and then click **Edit**. The **Edit Recall Action** window appears. Continue now to Step 6.
- **Delete** an existing action, select it from those available, and then click **Delete**. You will be prompted to confirm this. Note that this cannot be reversed.

5. The **Add Recall Action** window appears.

6. Indicate who performed the Recall Action via the associated drop-down list. Optionally, you can elect to include inactive/deleted practitioners/users in this list.

7. Indicate the type of action performed. This list of hard-coded actions includes:

Consultation **Other** **Send Email** **Send Fax** **Send Letter**
Send SMS **Telephone Business** **Telephone Home** **Telephone Mobile**



8. Enter the date on which the Action was performed.

9. (Optional) Record a comment if desired.

10. (Optional) Indicate whether you also wish this action to be recorded as an attempt to contact the patient.

11. Click **Save** to save the action to the patient's recall item.

About Actions (Recall vs. Outstanding)

Recall Actions

A Recall Action is a note recorded about a Recall that typically relates to correspondence / contact regarding a Recall.

For example, if you had sent a printed Recall reminder letter to a patient, and then followed-up that letter with a phone call, you may wish to record the fact that you made the phone call. This action can be recorded against the Recall within the patient's record. A single Recall can have an unlimited number of Recall Actions recorded against it.

A Recall Action is not to be confused with an Outstanding Action (see below).

See also Actions (Recall)

Outstanding Actions

An Outstanding Action is a practitioner's reminder notice about a specific patient, that appears on-screen upon opening their record. You can configure Clinical to present you with a pop-up list of Outstanding Actions for a specific patient. Alternatively, you can view a list of all Outstanding Actions for all patients, and then filter that list by practitioner or by type of Action.

Outstanding Actions are designed to remind the practitioner to perform one or more clinical actions for the patient, but can be used to record any reminder notice about the patient you desire.

An Outstanding Action is not to be confused with a Recall Action (see above).

See also Adding Outstanding Actions

Generating a Recall in Insights

The following steps show how you might generate a recall for patients. In this example we are going to generate a recall for an Asthma Review for those patients who have an active condition of Asthma.

1. Select **Conditions > Respiratory Prevalence**.

2. In our example, we want to see only those patients with an active condition of 'Asthma', so we select (click) the associate column in the visualisation.

○ When you select one or more regions in this way, your selection is shown at left (i.e. "1 region selected), and you are presented with a **View** button The list of associated patients appears.

MedicalDirector Insights

INSIGHTS | Collection | Demographics | SNAP | Measures | Conditions | Medications | Reporting

Cardiovascular Prevalence
Diabetes Prevalence
Mental Health Prevalence
Musculoskeletal Prevalence
Renal Prevalence
Respiratory Prevalence
STI Prevalence
Other Prevalence

Visualisation

Bar
Table

1 image available
Save PNG...

Respiratory conditions prevalence as a percentage of **regular active** patients

[total filter population = 15]

Ever had condition
Active condition

40%
30%
20%
10%
0%

Asthma
COPD
Other Respiratory

MedicalDirector Insights Patient Export

Preview from visualisation: 'Respiratory conditions prevalence as a percentage of **regular active** patients'

Export Patient Count
4 of 15
Export Data Criteria
Asthma Active condition

First | Previous | 1 | Next | Last

Name	Gender	DOB
ANDERSON, David	M	4/01/1955
ANDREWS, Fred	M	23/02/1923
ANDREWS, John	M	17/06/1968
WATLAND, Henry	M	29/02/1972

Export all as | Excel | HTML | CSV | TSV | Add Recall | OK

Generating a Recall in Insights

Note also that you can access such lists of patients via the supplied Reports:

4. Click Add Recall button You are presented with the Recall details for you to configure.

○ Indicate the Practitioner the Recall is being created on behalf of.

○ Indicate the reason for the Recall. In our example, we have selected 'Asthma Review'. If you select a reason from the list, its schedule settings are loaded for you automatically. You can modify these if you wish, and such modifications will not affect the reason definition, nor will they affect any Recalls already saved.

○ Indicate whether this is a once-only Recall, or a recurring Recall. For recurring Recalls, you must also indicate the interval between Recall visits.

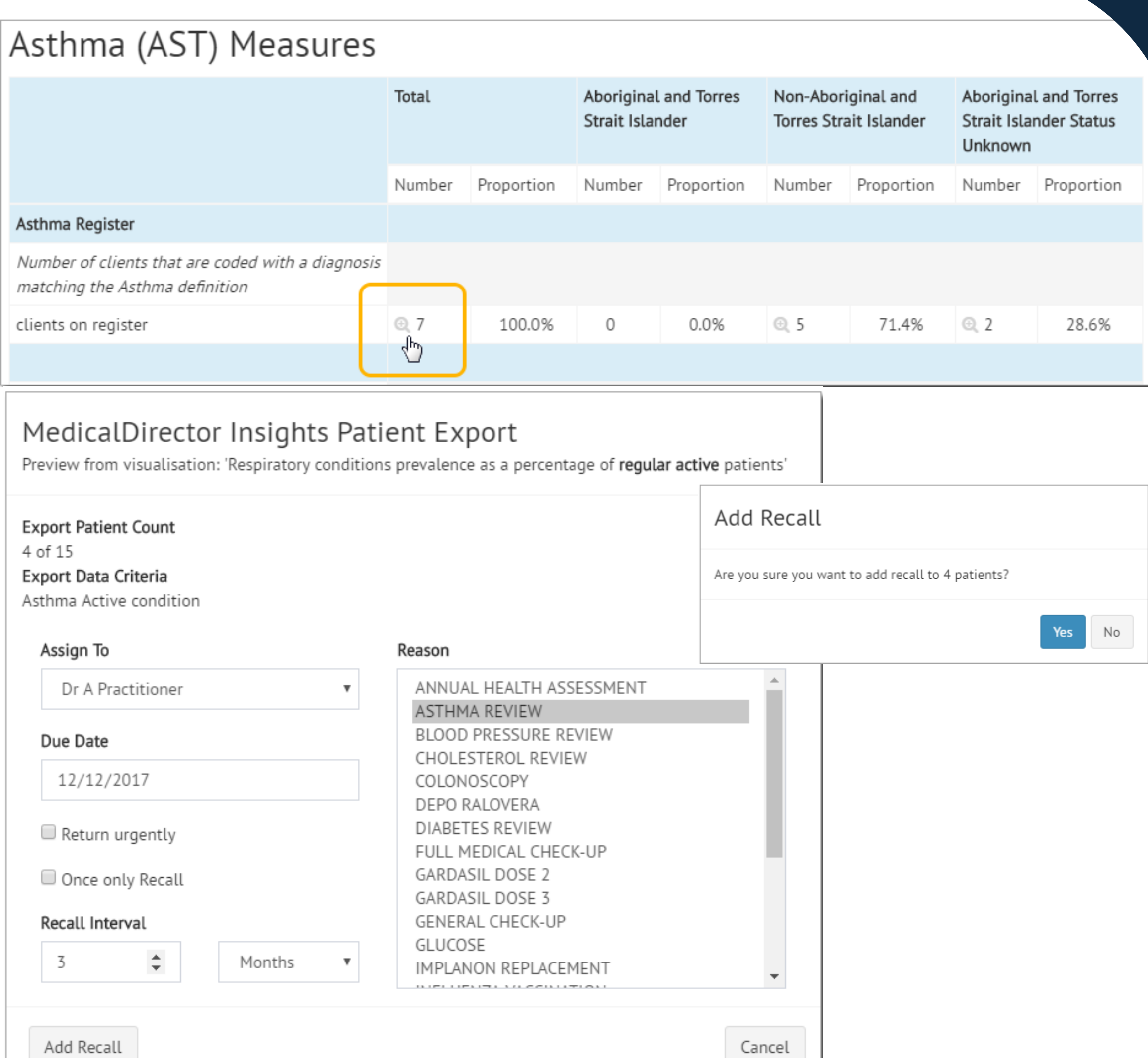
• For once-off Recalls, this is the date on which you wish the patient to return to the practice.

• For recurring recalls, this is the date on which you wish the first return visit to occur.

○ Indicate the Recall due date.

5. Click Add Recall button. You will be prompted to confirm this action.

6. Click Yes button to confirm. The recalls are added to Clinical. See Recalls for detailed information.



Recall & Reminders via Smart Marketplace Partner – AutoMed Systems

AutoMed Clinical Reminder Service (Recalls)

AutoMed can create a Rule per Reminder Reason.

Optionally add a catch all Rule that will send for ALL Reminder Reasons, including new ones going forward – Nothing Gets Missed.

The doctor adds the recall to the patients file with the Reason and Due Date

AutoMed automatically sends patients an SMS, a set number of days before it is due.

Select whether to send plain or secure SMS and enter a specific message per reminder type.

Choose which reminders should send, when they should be sent and what they should say.

Set it up once and it runs automatically, no manual allocation of templates required.

Automatic 2nd Discuss SMS if patient has not booked an appointment within the required number of days.

Automatically creates mail merges, with bulk export function, for patients who can't be contacted by SMS, Opted Out, or have not attended after all contact attempts.

Optional ad-hoc 3rd SMS or restart Message Cycle per recall.

All contact attempts and correspondence saved to the patient's record.

AutoMed provides one on one Online Staff Training sessions using Clinics own data.

An Advanced Reporting feature provides real-time interactive snapshots, directly from PracSoft of all Recalls & Results, their status, contact attempts, Assoc practitioners and contact notes.

Clinical Reminders + Add Clinical Reminder

	Name	Description	Recall Days	Template	Submit Hours	Delete
	12mth Immunisation	12mth Immunisation	1	CR - Childhood Imms	Between 8 & 19	
	2mth Immunisation	2mth Immunisation	1	CR - Childhood Imms	Between 8 & 19	
	4-5y Immunisation	4-5y Immunisation	1	CR - Childhood Imms	Between 8 & 19	
	4mth Immunisation	4mth Immunisation	1	CR - Childhood Imms	Between 8 & 19	
	6mth Immunisation	6mth Immunisation	1	CR - Childhood Imms	Between 8 & 19	
	ADF Post Discharge GP Health Assessment	Do not send	-1	Custom Message	Between 8 & 19	
	Asthma review	Asthma review	7	CR - Default with Tag	Between 8 & 19	
	BP Check	BP Check	7	CR - Default with Tag	Between 8 & 19	
	Breast check	Breast check	7	CR - Default with Tag	Between 8 & 19	
	Care plan	Care plan	1	CR - Care Plan	Between 8 & 19	

AutoMed Services Overview

BENEFITS

Save time, and money outbound call costs and create revenue from Recall appointments.

AutoMed Recalls ensures that you contact all patients for upcoming reminders with specific content and rules t match, keeping your practice complaint and accreditation ready.

Recall & Reminders via Smart Marketplace Partner – Automed Systems

AutoMed Results Service (Callbacks)

AutoMed's unique, sophisticated results messaging system automatically sends specified messages to your patients when the practitioners have reviewed correspondence or investigations and marked them as No Action, Discuss or Urgent Appointment

Messaging runs every hour during business hours.

Configurations available to include / exclude certain action types.

Ultimately the system aims to send a single message to the patient, for the highest assigned action, for a batch of results.

If your preference is that the patient receive individual messages per pathology or radiology provider, this can be configured.

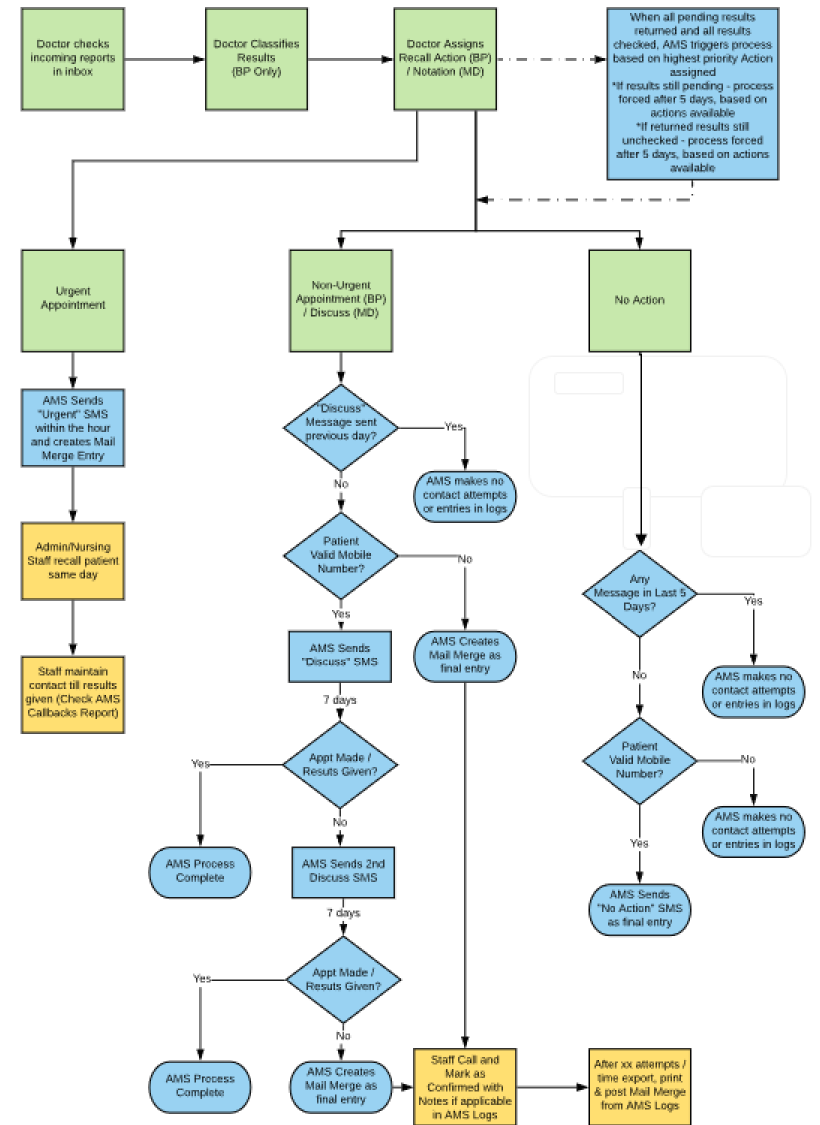
SMS can be set to insert the Doctors Comment associated with the Result to personalise the communication.

Automatic 2nd message if patient has not booked an appointment within the required number of days.

Automatically creates mail merges, with bulk export function, for patients who can't be contacted by SMS or have not attended after all contact attempts.

Comprehensive message logs All contact attempts and correspondence saved to patient's record.

The Advanced Reporting feature within AutoMed provides a real-time snapshot of all results, their current status, as well as past and upcoming appointments to provide the most comprehensive display of data integrated between AMS and PracSoft.



AutoMed Services Brochure

BENEFITS

Save Staff time and costs by reducing calls to reception regarding Results by up to 95% by keeping your patients informed as to their results and the action required.
AutoMed delivers and receives all SMS' via a Tier 1 Enterprise Message Gateway
Unlimited SMS
160 -900 characters if required.

Recall & Reminders via Smart Marketplace Partner - Healthengine

Patient Recalls & Clinical Reminders with Healthengine

Automate your clinical reminders and recalls with ease
Free up valuable time across your team with quick, easy and automated patient recalls via SMS, letters or phone calls. The choice is yours. Experience the convenience of Healthengine's new and improved Recalls, tailor-made to elevate your practice efficiency.

Recalls for your practice, your way
Healthengine's Recalls puts the control in your hands for both clinical reminders and recalls. Easily set your parameters based on the needs of your patients and your own practice preferences. Choose your sequencing (e.g. two SMS sends, followed by a letter), the type of recall or clinical reminder (e.g. urgent result), specify your contact timeframes and away you go.

Reduced workload, reduced expenses
Recalls is a flexible solution, tailor made and setup for each individual practice on Healthengine. This allows you to choose the level of automation versus manual input, letting your team rapidly process recalls and clinical reminders at both pace and scale. Now you can give valuable time back to your team, allowing you to focus on providing an exceptional experience for patients.

What's new for Recalls

- PMS locations can be viewed for each patient recall
- Add patients to your block list for SMS messages
- We've reduced unnecessary notes sent to your PMS

Recalls experience in action practice efficiency

The benefits of Recalls with Healthengine:

- Unlimited SMS recalls and clinical reminders included for practices on **GP Complete**
- Free up staff time across the team by automating your recalls and clinical reminders process
- Choose, customise and edit your level of automation versus manual input
- Set your own parameters for clinical reminders, urgent and non-urgent recalls
- Choose how and when recalls and clinical reminders are sent (via SMS, letter, phone call)
- Save costs on printing and stationery with our SMS and phone call recall options
- Secure three-step ID verification for patients when receiving recalls
- Audit notes are logged automatically in your PMS for a complete audit history

Recall & Reminders via Smart Marketplace Partner - HotDoc

HotDoc Clinical Reminders (Recalls)

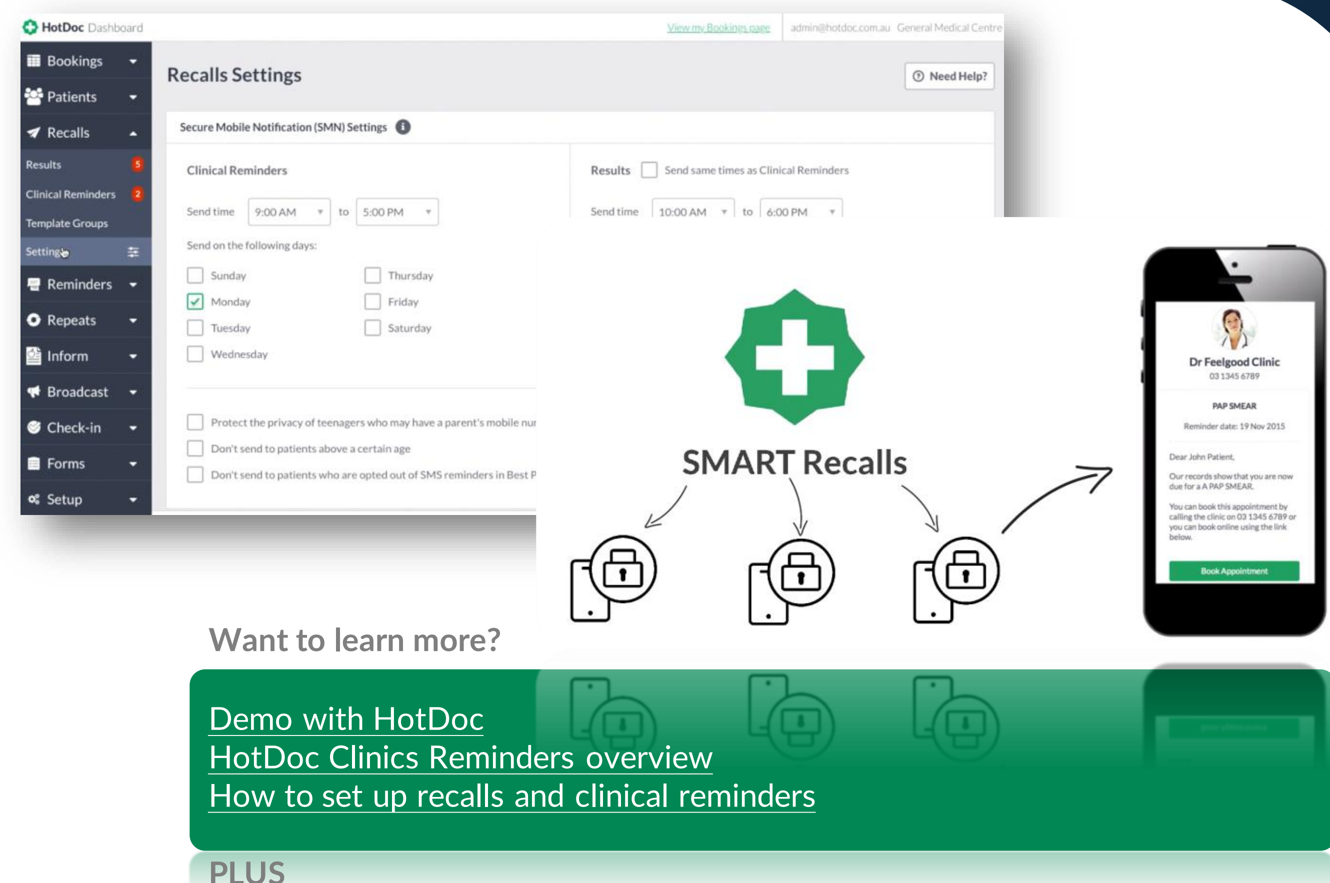
HotDoc Recalls is a system that handles both Results and Clinical Reminders and allows you to securely send SMN messages and push notifications to patients if they have an upcoming recall in their patient file.

How does it work?

1.
A doctor adds a recall into a patient's record, this is usually entered with a **recall reason** and a **due date**.
2.If the recall is unresolved and has a due date within the syncing window HotDoc will bring it into the **dashboard.**
3.Once HotDoc has synced a clinical reminder into the Dashboard, it will **automatically send out** a push notification or SMN depending on whether the recall has been attached to an applicable template.

HotDoc syncs and displays the following as part of the recall:

•Patient name
•Recall Reason (as outlined in the patient record)
•Due date
•Mobile number
•Date of Birth
•Doctor performed (if linked correctly)
•Patient's next appointment date



Want to learn more?

[Demo with HotDoc](#)
[HotDoc Clinics Reminders overview](#)
[How to set up recalls and clinical reminders](#)

PLUS

HotDoc users get access to the online Academy Training platform and regular Live Training Sessions to learn or refresh their recalls knowledge.

Recording Social and Family History

Data recorded here is available to the Letter Writer where it can be merged into letters and e-mail correspondence. Family History and Social History data will also appear on the Summary tab.

Item	Criteria
ADF Service	Indicate the patient's service (if any) with the Australian Defence Force. A patient's service status; •Is displayed within the Occupation field located towards the top of the Clinical Window. •May affect whether you are prompted to perform an assessment for them upon opening their clinical record.
Update Address for All Family Members check box	Update the address details for other family members, with the details of the current patient. Clinical uses the Head of Family. setting to determine which patients are members of the same family. This option is only available when editing Patient Details from the Clinical Window.
Auto-Capitalise Names check box	Tick the Auto-Capitalise Names check box to automatically capitalise the first letter of each word you type. There are numerous windows throughout MedicalDirector Clinical that offer this functionality, including the various Options tabs.

Patient Details

Pt. Details | Allergies/Adverse Reactions/Warnings | Family/Social Hx | Notes | Smoking | Alcohol | Personal Details

Relationship Status: Single
Occupation: Retired
Sexuality: Unknown
ADF Service:

Family History:
Parents died due to car crash.
Brother died to a heart attack

Social History:

Ctrl + D

Patient > Details

Update address for all family members
Auto-capitalise names

Save
Cancel

Recording Alcohol

The AUDIT-C assessment can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10-question AUDIT instrument. The AUDIT-C is scored on a scale of 0–12. Each AUDIT-C question has five answer choices. Points allocated are:

a = 0 points b = 1 point c = 2 points d = 3 points e = 4 points

- In men a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- In women a score of 3 or more is considered positive (same as above).

The recording of data on this tab is for your records only; it plays no part in the functioning of other modules within Clinical, except for the Letter Writer where some of this information can be merged into letters.

•Click **View Alcohol Guidelines** to open a window of information on alcohol consumption.
•Click **Reference** to open the World Health Organisation's web page 'Screening and brief intervention for alcohol problems in primary health care'.
•Click **New Assessment** to record a new assessment. This clears data from the window, ready for your new assessment. Once you completed the assessment, click **Save** to save the data. A new entry will be added to the list of assessments, located at the top-right of this window.

- A note is also added to the patient's Progress Notes.
- Information you save here is reflected in the patient's Health Assessment, and ATSI Health Assessment (for eligible patients).
- The latest assessment is always displayed by default when you access the Alcohol tab.

•To view a previous assessment, locate and double-click a previous assessment from the list at the top-right of this window.
•Click **Delete** to delete a previous assessment.
•**Update Address for All Family Members** check box: Update the address details for other family members with the details of the current patient. Clinical uses the Head of Family setting to determine which patients are members of the same family. This option is only available when editing Patient Details from the Clinical Window.
•**Auto-Capitalise Names** check box:Tick the **Auto-Capitalise Names** check box to automatically capitalise the first letter of each word you type. There are numerous windows throughout MedicalDirector Clinical that offer this functionality, including the various Options tabs.

Patient Details

Pt. Details | Allergies/Adverse Reactions/Warnings | Family/Social Hx | Notes | Smoking | Alcohol | Personal Details

Date of assessment: 18/02/2013

Audit-C Assessment

1. How often do you have a drink containing alcohol?
Never | Monthly or less | 2-4 times a month | 2-3 times a week | 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?
1 or 2 | 3 or 4 | 5 or 6 | 7 to 9 | 10 or more

3. How often do you have six or more drinks on one occasion?
Never | Less than monthly | Monthly | Weekly | Daily or almost daily

Audit-C Total Score: 3

In men a score of 4 or more and in women a score of 3 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. The guidelines to reduce health risks from drinking alcohol provide further assessment and treatment options.

Patient concerned about drinking?
Yes | No | Don't know

View Alcohol Guidelines | Reference | New Assessment

Date	Time	Score	Concerns	Comments
18/02/2013	00:00:00	3	No	No

Delete

Comments

Currently displaying data from assessment performed on 18/02/2013. Click 'New Assessment' to conduct a new assessment.

Ctrl + D

Patient > Details

Update address for all family members
Auto-capitalise names

Save | Cancel

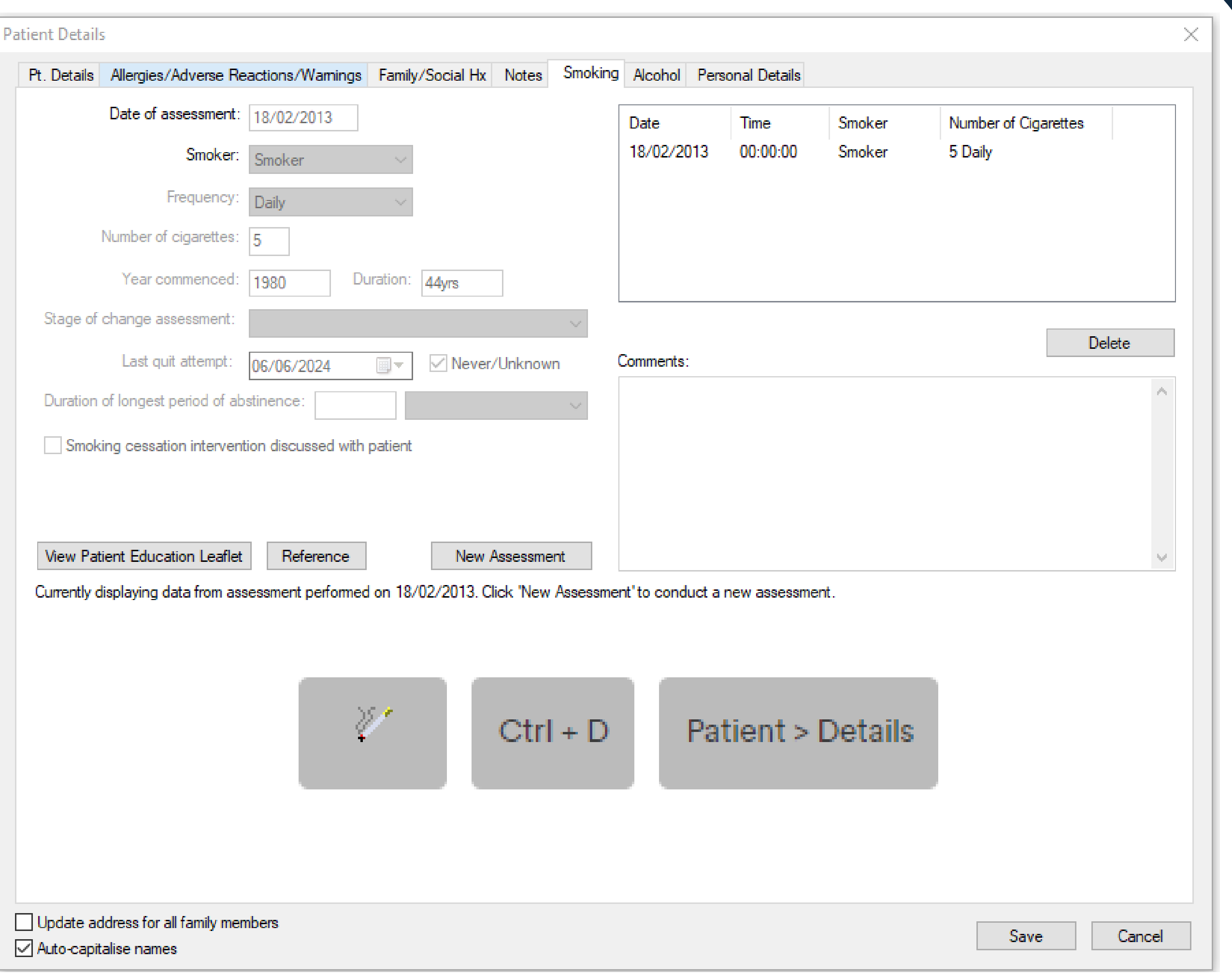
Recording Smoking

The recording of data on this tab is for your records only; it plays no part in the functioning of other modules within Clinical, apart from the Letter Writer where this information can be merged into letters.
Click **View Patient Education Leaflet** to open a pre-selected PDF leaflet entitled 'Smoking - Quitting'. This leaflet is one of many Patient Education leaflets available.

Smoking cessation intervention discussed with patient check box: Ticking this box flags patients for the Smoking Cessation report found in MedicalDirector Insights.

Update Address for All Family Members check box: Update the address details for other family members, with the details of the current patient. Clinical uses the Head of Family. setting to determine which patients are members of the same family. This option is only available when editing Patient Details from the Clinical Window.

Tick the **Auto-Capitalise Names** check box to automatically capitalise the first letter of each word you type. There are numerous windows throughout MedicalDirector Clinical that offer this functionality, including the various Options tabs.



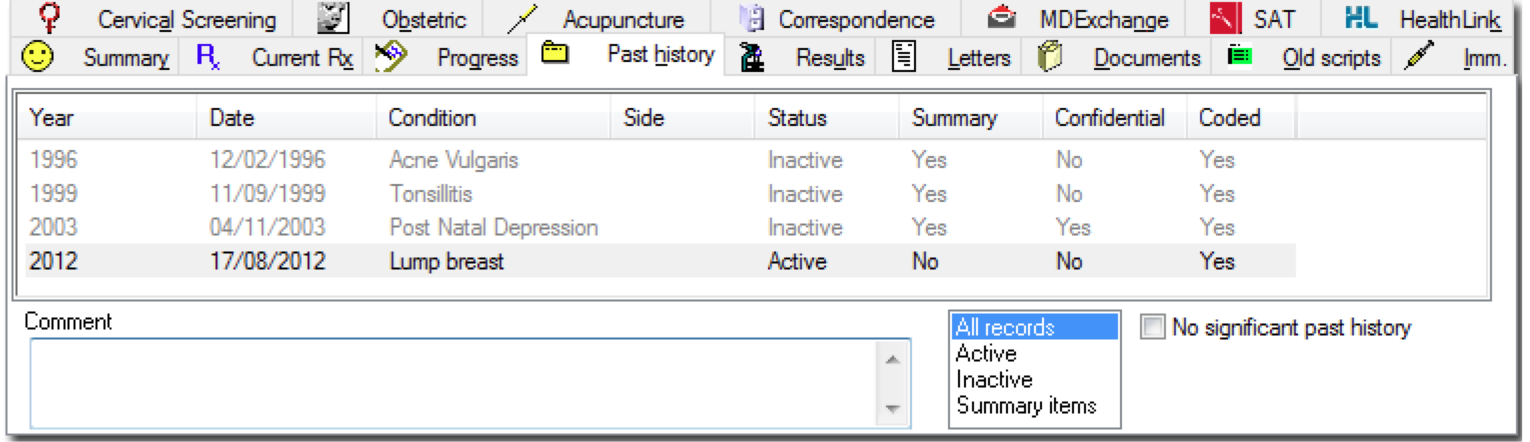
Keeping Past History items relevant

The Past History tab displays a summary of the patient's medical history. This is not to be confused with a patient's clinical progress, as recorded via Progress Notes.
Coded: Indicates if the diagnosis was made by selecting from the DOCLE list of diagnosis.

Comment: Displays comments relating to a given past history entry. This window is read-only.

Types of History Records: Filter the past history records by All Records, Active, Inactive (displayed in grey), or Summary

No Significant Past History: If the patient has no significant clinical history to make a note of, indicate this by ticking this check box. A prompt to remind you to check this status with your patient is managed from within Prompt/Preventive Health Options. To view a percentage of patients who have not been asked about their past history status, see Clinical Data Statistics. You can also print a list of patients from this search utility.



When viewing all records, inactive items are displayed in grey.

Creating letters

Letters are created and edited with the Letter Writer.

1. Open the Letter Writer by either:

○ Selecting **Tools > Letter Writer** from the Clinical front screen,

○ Pressing **F8**,

○ Clicking on the tool bar within the patient's Clinical Window,

○ Selecting the Letters tab within the patient's Clinical Window, and clicking the button,

○ Selecting the Letters tab within the patient's Clinical Window and clicking **Add**.

○ Selecting the Correspondence tab within the patient's Clinical Window, clicking **Add**, and selecting **Letter** from the menu that appears..

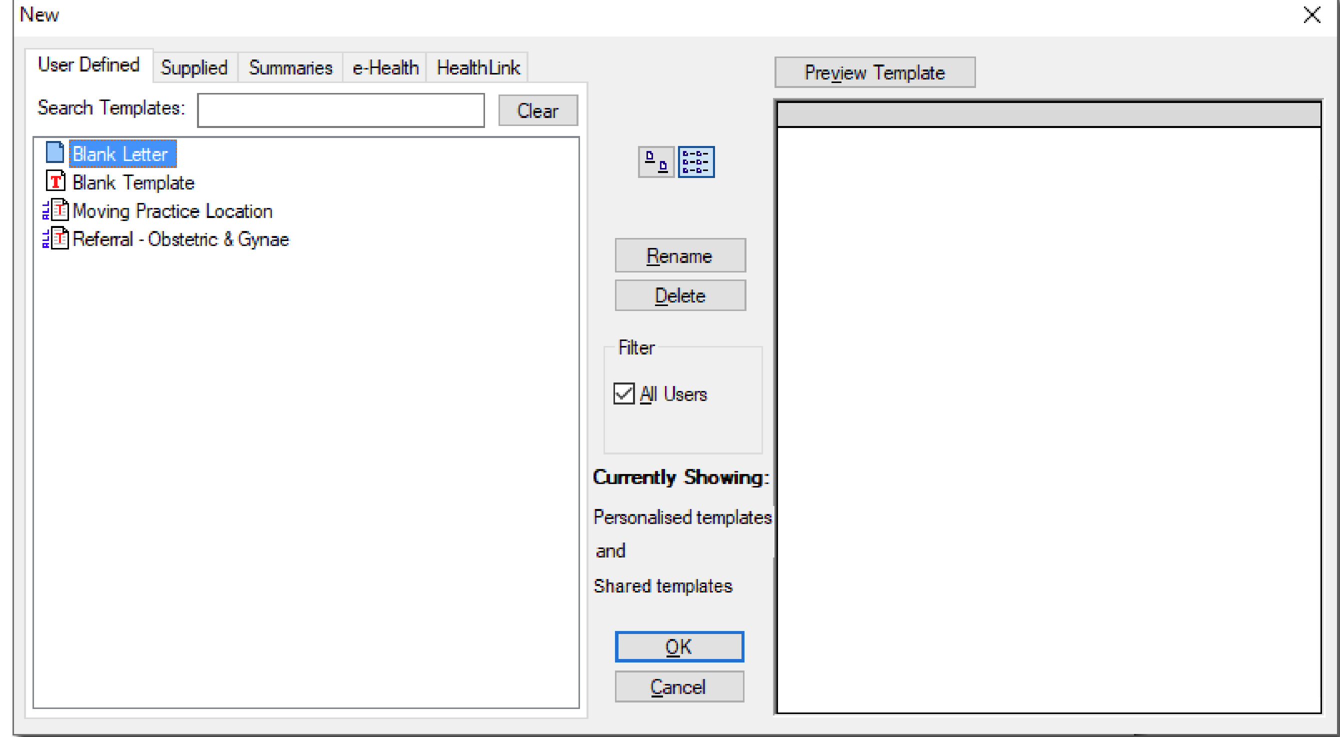
2. Within Letter Writer, to create a new letter either;

○ Click on the tool bar, or

○ Select **File > New**, or

○ Press **CTRL+N**

3. The **New** window appears.



4. Double-click the template you wish to base the new letter on, or create a new template by selecting Blank Template. Alternatively you can search for a template using the box provided.

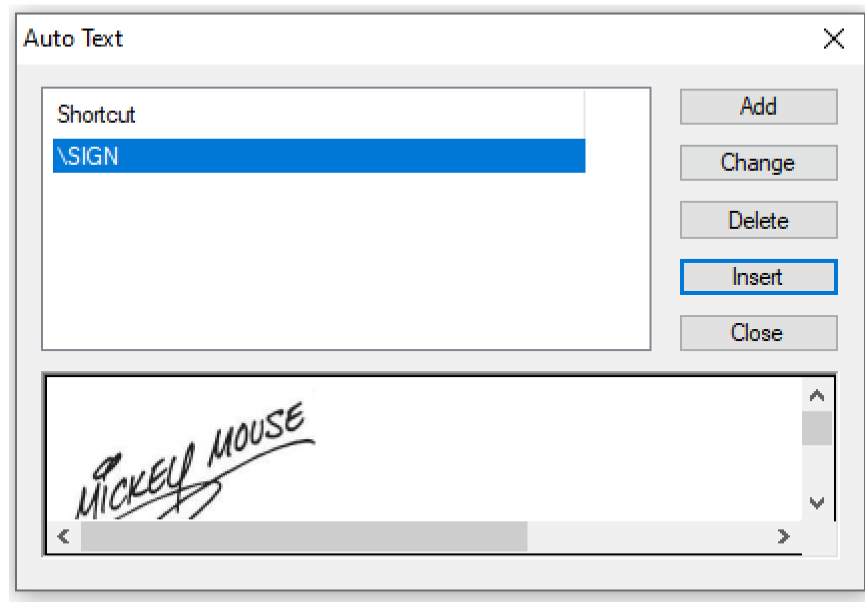
See Letter Writer for more information about creating and editing letters.

Auto Text – Adding Signature

Auto Text functionality allows you to quickly insert bodies of text into a letter using a single keyword or phrase. For example, instead of having to repeatedly type your entire salutation every time you create a new letter, you can program Letter Writer to insert it automatically upon typing a single keyword or phrase, such as 'mysalutation'.

There is no limit to the number of Auto Text entries, or the length of each entry that can be stored in Letter Writer, and you can share the Auto Text entries you create with other users.

- Managing Auto Text
- Creating and Editing Auto Text



1. From within Letter Writer, either;

   - Select **Edit > Auto Text**
   - Press **Ctrl+T**

2. The **Auto Text** window appears.

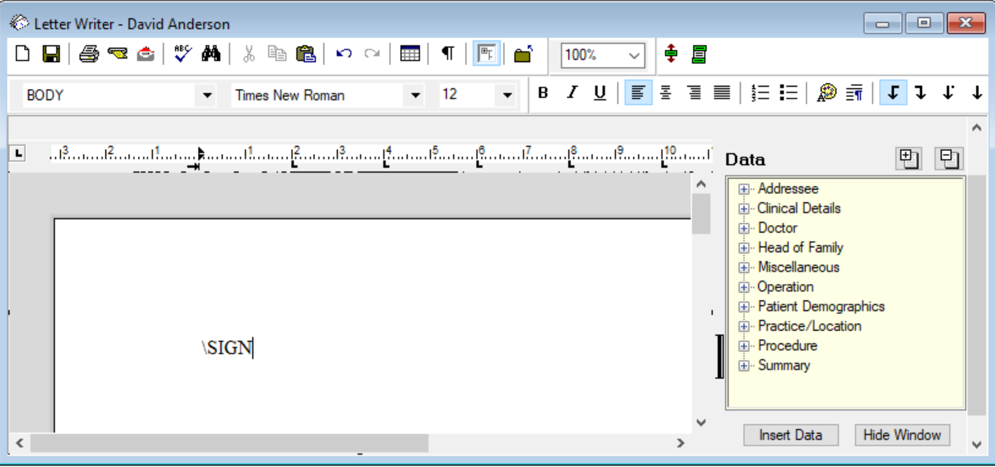
3. From here you can;

   - Add a new Auto Text entry (eg \SIGN)
   - Change an existing Auto Text entry (see below for detailed information)
   - Delete an existing Auto Text entry, by selecting it in the Shortcut window and clicking **Delete** button.
   - Insert an existing Auto Text entry, by selecting it in the Shortcut window and clicking Insert button or a Picture of your signature by pasting and edit size.

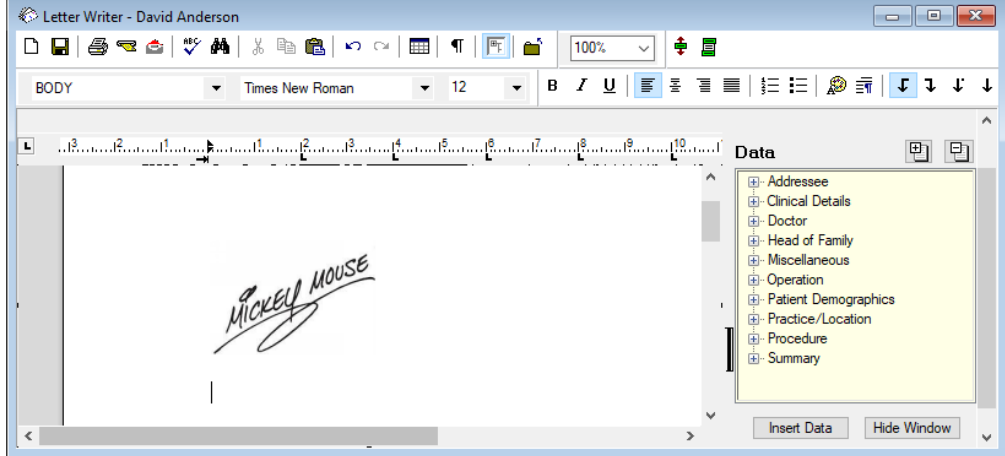
Health
Primary, Aged &
Community Care

Auto Text – Adding Signature

The following example shows how you can also insert Auto Text into your document by typing the keyword shortcut associated with that Auto text entry.



This example uses a keyword shortcut of ***\SIGN***. Upon typing this keyword, Letter Writer would detect that the text you typed may relate to one of the Auto Text entries you have created, and display a pop-up window containing the associated Auto Text. If you wanted to add the Auto Text to your document, you would simply press the Enter key on your keyboard, and the Auto Text would be added to the page automatically, as shown below.



My Health Record Accessing

With Clinical configured correctly, you can access a patient's My Health Record documentation via the My Health Record menu within the patient's Clinical Window. You will be presented with the My Health Record window, an example of which is shown below.

Note that when you first access the My Health Record system, you will be prompted to complete your user name details. You will only be asked this once.

Allows you to gain access to documents that have been password-protected by the patient - it is the patient who controls access to their My Health Record documentation.

Any document can be applied one of two access levels;

•Open: the document is unrestricted.

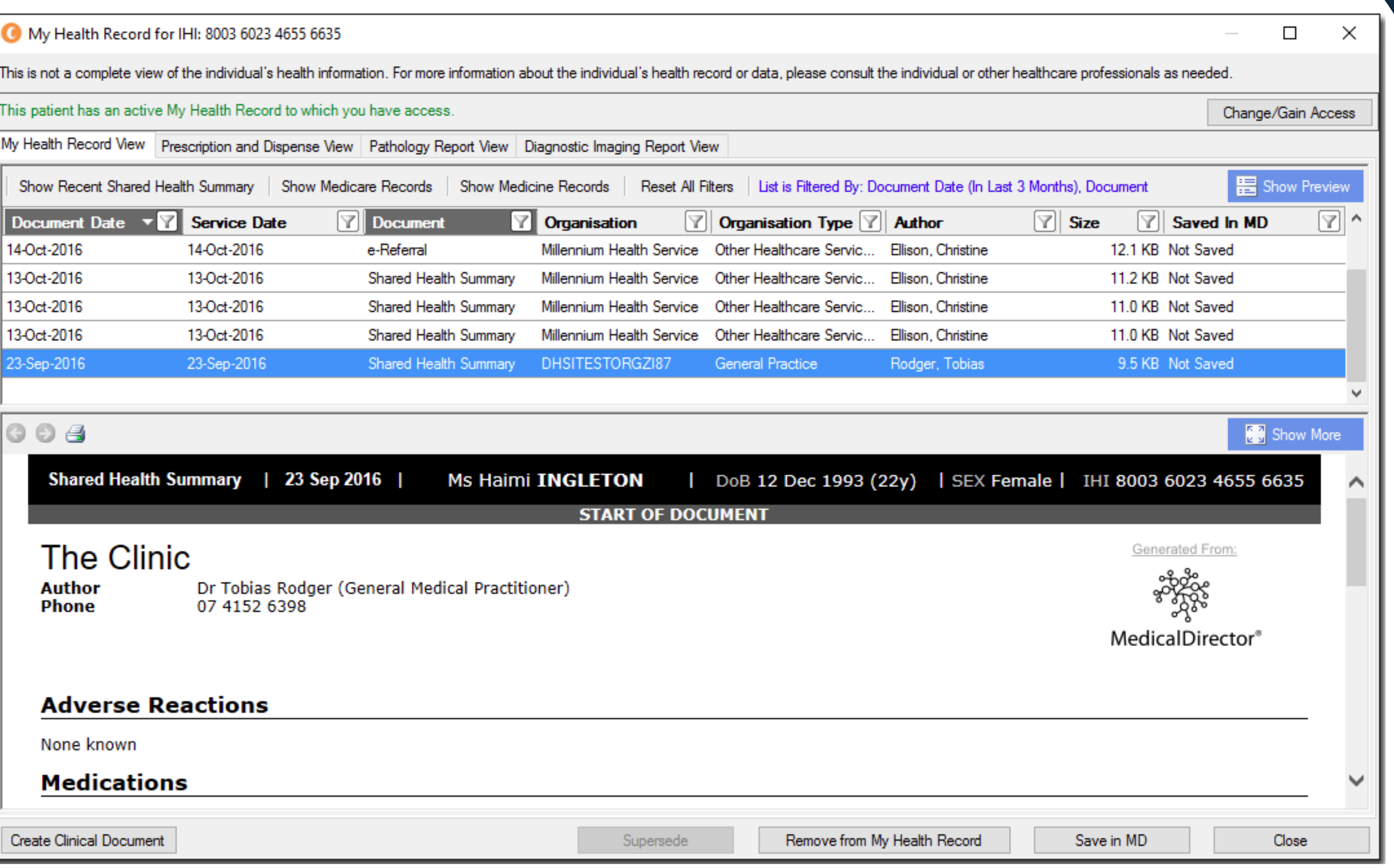
•Code: the document requires an access code to view/download.

Click the Change/Gain Access button, and then select from the three Access Type options;

•Open Access: no access code required.

•Access Code: enables the Access Code field in which you must enter the access code the patient provided you.

•Emergency: grants you access to password-restricted documents for five days. To be used in an emergency when the patient cannot be contacted. A record of the document being accessed in this fashion may be sent to the patient.



Removes a selected document from the My Health Record system. This is only available if you are the creator of the original document, or it was created by another user from the same Practice (i.e. with the same Practice HPI-O recorded via Tools > Options > Practice tab.

My Health Record accessing Prescription & Dispense

The Prescription and Dispense View tab lists prescribed/dispensed medications that the patient has granted consent to upload to the My Health Record System. Consent is typically indicated via the Enter Dose window during the prescribing process, but can also be granted/revoked afterwards by right-clicking an item on the CurrentRx tab and clicking the My Health Record Consent entry from the menu that appears. This functionality requires that you have enable ePrescribing.

To view a medication on this window;

1. First, expand the medication details by clicking the ▸ button at the far left end of the medication row.

2. Secondly, click the medication details. The script details will be revealed

My Health Record for IHI: 8003 6081 6669 0511

This is not a complete view of the individual's health information. For more information about the individual's health record or data, please consult the individual or other healthcare professionals as needed.

This patient has an active My Health Record to which you have access. | Change/Gain Access

My Health Record View | Prescription and Dispense View | Pathology Report View | Diagnostic Imaging Report View

Event Date 2/02/2000 To 22/11/2016 Filter | Group by Prescription

Collapse List | Expand List | Show Preview

SHAUN LEE | DoB 15-Mar-1979 (37y) | SEX Male | IHI 8003 6081 6669 0511

START OF RECORDS **- This view is not a complete record of the individual's medicines information.**

Prescribed	Medicine Details		First Dispense	Last Dispense	Dispensed
2-Oct-2014	**ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE**		unavailable	unavailable	unavailable
2-Oct-2014	Prescribed	**Therapeutic Good Generic Name** — ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE — Therapeutic Good Strength — Directions — Film-coated tablet — *Supply Dispensing Information - Quantity* — Dispense original and 5 repeats			
1-Oct-2014	**ALUMINIUM HYDROXIDE with MAGNESIUM HYDROXIDE**		unavailable	unavailable	unavailable
1-Oct-2014	Prescribed	**Therapeutic Good Generic Name** — ALUMINIUM HYDROXIDE WITH MAGNESIUM HYDROXIDE — Therapeutic Good Strength — Directions — Film-coated tablet — *Supply Dispensing Information - Quantity* — Dispense original and 5 repeats			

MedicalDirector Clinical Stylesheet Version: 1.1.0.0 (based on NEHTA PCEHR Prescription And Dispense View CDA Stylesheet Version: 1.1.0)

END OF RECORDS

Create Clinical Document | Save in MD | Close

My Health Record accessing Pathology Report

My Health Record for IHI: 8003 6081 6669 0511

This is not a complete view of the individual's health information. For more information about the individual's health record or data, please consult the individual or other healthcare professionals as needed.

This patient has an active My Health Record to which you have access. | Change/Gain Access

My Health Record View | Prescription and Dispense View | Pathology Report View | Diagnostic Imaging Report View

Specimen Collection Date 02-Feb-2000 To 22-Nov-2016 Filter | Group by No Grouping | Search | Organisation ALL | Clear

Collapse List | Expand List | Show Preview

SHAUN LEE | DoB 15-Mar-1979 | SEX Male | IHI 8003 6081 6669 0511

Tests Found: 15 **Tests Matching:** 15

START OF RECORDS

Specimen Collected Date	Report Date	Pathology Organisation	Requesting Organisation	Pathology Discipline	Test Name	Test Status	Report ID
10-Dec-2014	12-Dec-2014	Burrill Lake Medical	Bodalla Clinic	Hematology	Blood Test	Final	123A45
31-Aug-2014	04-Sep-2014	Coomerante Hospital	E L C Coomera Centre	Chemistry	Serum chemistry test	Final	14P0175
09-Jun-2014	12-Jun-2014	Burrill Lake Medical	Bodalla Clinic	Hematology	Blood test	Final	14F007
01-Mar-2014	02-Mar-2014	Burrill Lake Medical	Bodalla Clinic	Hematology	Blood test	Final	WA08666
10-Jan-2014	12-Jan-2014	Coomerante Hospital	Bodalla Clinic	Hematology	Blood test	Final	14P1050

Create Clinical Document | Save in MD | Close

MedicalDirector

My Health Record accessing Diagnostic Imaging Report

My Health Record for IHI: 8003 6081 6669 0511

This is not a complete view of the individual's health information. For more information about the individual's health record or data, please consult the individual or other healthcare professionals as needed.

This patient has an active My Health Record to which you have access. Change/Gain Access

My Health Record View | Prescription and Dispense View | Pathology Report View | Diagnostic Imaging Report View

Event Date 22-Nov-2009 To 22-Nov-2016 Filter Group by No Grouping Search Organisation ALL Clear

Collapse List Expand List Show Preview

SHAUN LEE | DoB 15-Mar-1979 | SEX Male | IHI 8003 6081 6669 0511

Examinations Found: 51 **Examinations Matching:** 51

START OF RECORDS

Imaging Date	Organisation	Examination	Modality	Anatomical Region	Anatomical Location	Laterality
16-Apr-2015	New Organisation	Pelvis X-ray (procedure)	Pelvis X-ray (procedure)	Pelvis	Entire thorax (body structure)	Right and left (qualifier value)
16-Apr-2015	New Organisation	Plain chest X-ray (procedure)	Radiographic imaging procedure (procedure)	N/A	Chest/Thorax Bi-Lateral	N/A
16-Apr-2015	New Organisation	Plain chest X-ray (procedure)	Radiographic imaging procedure (procedure)	N/A	Chest/Thorax Bi-Lateral	N/A
16-Apr-2015	New Organisation	Plain chest X-ray (procedure)	Radiographic imaging procedure (procedure)	N/A	Chest/Thorax Bi-Lateral	N/A

Create Clinical Document | Save in MD | Close

My Health Record uploading while Prescribing

With a patient's consent, prescriptions can be uploaded to their My Health Record. The upload occurs automatically when you print a script. Consent is typically indicated via the Enter Dose window during the prescribing process, but can also be granted/revoked afterwards by right-clicking an item on the CurrentRx tab and clicking the My Health Record Consent entry from the menu that appears.

The National Prescription and Dispense Repository (NPDR) is a subset of a patient's My Health Record and allows for the creation of an online medication history (for both prescriptions and dispensing). Transfer of medications in this way requires you are registered for ePrescribing and have enabled eRx Script Exchange.

Prerequisites:

- Practitioner is registered for ePrescribing. *See* ePrescribing Configuration *for instructions.*
- My Health Record is configured correctly. *See Configuring MedicalDirector Clinical for My Health Record for instructions.*
- Practitioner has indicated their participation in My Health Record. *See below for details.*

For further information regarding the NPDR, please refer to the following link:

www.ehealth.gov.au/internet/ehealth/publishing.nsf/Content/faqs-hcp-managing#anchor11

Enter Dose

ASPIRIN EC TABLET 100mg

Drug details
Dose: 1 tablet daily
PI | Monograph

Route of Admin: Oral - Swallowed

Purpose of action
- Print prescription (selected)
- Hand-written prescription
- Product advised here
- Product supplied here
- Advised or prescribed elsewhere

Dose: 1
Calculate

Frequency: Stat, Daily, Every alternate day, Every third day, In the morning, Midday, At night, Twice a day, 3 times a day, 4 times a day, Two hourly, Four hourly, Six hourly, Eight hourly, Weekly, Nil (selected)

Instructions: Nil (selected), If required, As directed, Before meals, With meals, After meals, Left side, Right side, To both sides, Plus as required, Other

Duration of medication
- Long term
- Limited (selected)

☑ Send to MyHealthRecord

Active Ingredient Prescribing
☐ Include brand name on script
☐ Brand substitution not allowed

ePrescribing Options (included with ePrescription token only)
Note to Pharmacist

☐ Exclude from Active Script List

Direct Dispense
(Do not provide to patient, provide directly to pharmacy)
☐ Script Owing (Medication already supplied)

☐ Unusual dosage | Pharmacy to dispense

Start date of medication: 3/05/2022

☐ Add to favourites | ☐ Save as default | Ok | Cancel

My Health Record uploading Documents

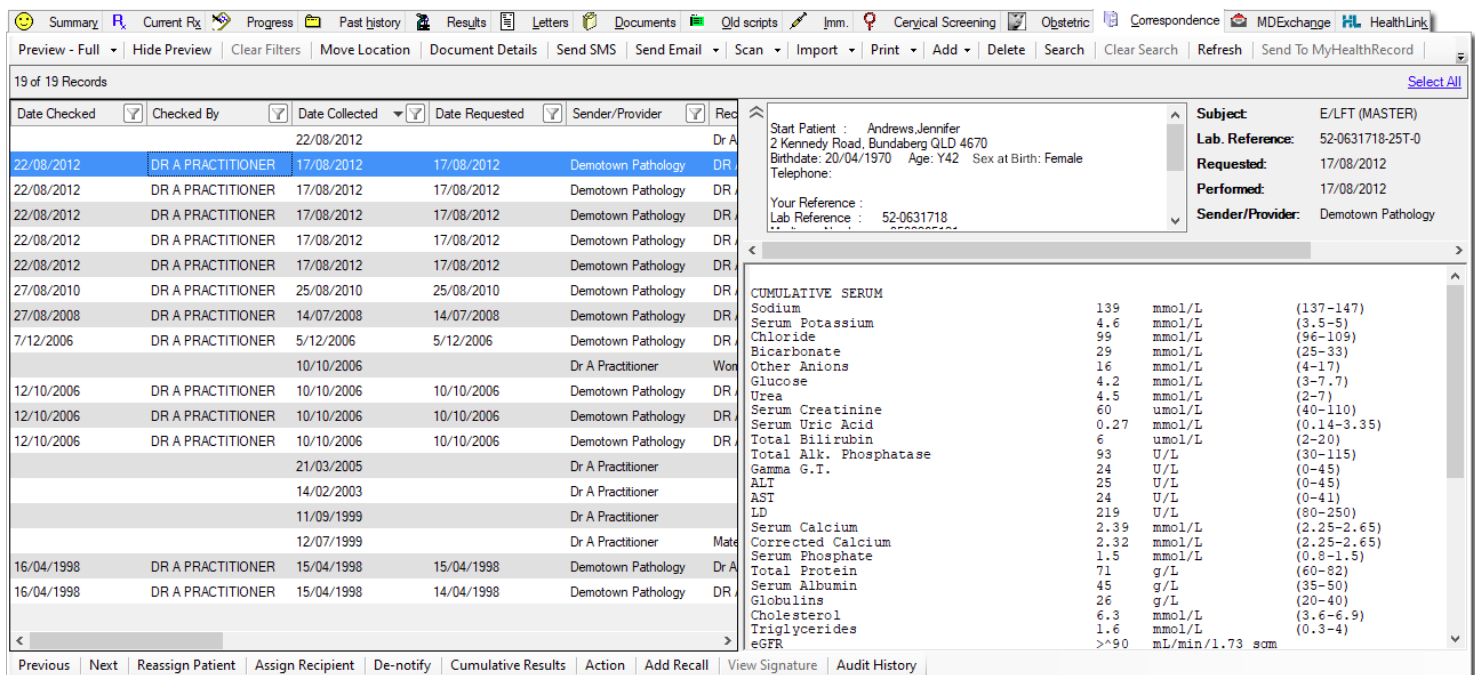
1. Create a CDA document via one of the supplied e-Health templates in Letter Writer.

2. Then, within the patient's record, locate the document you wish to upload. Documents can reside on either of the Correspondence, Documents, Results or Letters tabs.

3. Click Send To **MyHealthRecord** button. You will be presented with a preview of the document.

4. If you are satisfied that this is the document you wish to upload, click Send on the preview window.

5. The upload will commence and you will be notified upon completion. The 'My Health Record Status' and 'My Health Record Activity Date' columns within the correspondence tabs of the patient's record will indicate the selected document's My Health Record status.



My Health Record Saving, Superseded or Removed

1. Within the patient's record, select the My Health Record menu. You will be presented with the My Health Record window.

2. Locate and select the document you wish to download.

3. Click **Save in MD** button.

- If the document is of type 'Shared Health Summary' or 'Event Summary' it is saved to the Documents tab of the patient record. Documents of type 'e-Referral' or 'Specialist Letter' are saved to the Letters tab.
- If the document already exists in the patient's record (it has already been downloaded from My Health Record), you will be notified accordingly.
- If the document already exists in the patient's record, but on the My Health Record system there is a newer version of it, the document will be downloaded to the patient's record, and the older version will be retained within the patient's record for historical purposes.
- The 'My Health Record Status' and 'My Health Record Activity Date' columns within the Documents/Letters tabs will indicate the selected document's My Health Record status, such as 'Uploaded', 'Downloaded', 'Superseded', or 'Removed'.

My Health Record for IHI: 8003 6080 0002 4042

This is not a complete view of the individual's health information. For more information about the individual's health record or data, please consult the individual or other healthcare professionals as needed.

This patient has an active My Health Record to which you have access. Change/Gain Access

My Health Record View | Prescription and Dispense View | Pathology Report View | Diagnostic Imaging Report View

Show Recent Shared Health Summary | Show Medicare Records | Show Medicine Records | Reset All Filters | List is Filtered By: Document Date (In Last 3 Months), Document | Hide Preview

Document Date	Service Date	Document	Organisation	Organisation Type	Author	Size	Saved In MD
05-Dec-2013			MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	12.9 KB	Not Saved
05-Dec-2013	17		MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	9.0 KB	Not Saved
16-Dec-2013	25		MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	9.6 KB	Not Saved
24-Feb-2014			MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	9.7 KB	Not Saved
24-Feb-2014		Event Summary	MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	9.7 KB	Not Saved
24-Feb-2014		Shared Health Summary	MEDTESTORGSB52	General Practice	Terri-Anne, Alfonso	11.5 KB	Not Saved

Save in MD
Remove from PCEHR
Supersede

Show More

e-Referral | 28 Mar 2014 | Mr Lindsay BLANTON | DoB 1 Oct 1991 (22y) | SEX Male | IHI 8003 6086 6667 0989

START OF DOCUMENT

MedicalDriector Demo - David Harris

Author Dr Alfonso Terri-Anne (General Medical Practitioner)
Phone 02 9897 1212

Referral Detail

Date and Duration

Create Clinical Document | Supersede | Remove from My Health Record | Save in MD | Close

Clinical communities

Better management of patient outcome as a result of safer and better quality communication between clinicians involved in patient care. Proactively manage patients between consultation.

Clinical education

Targeted interventions enable better patient outcomes by empowering clinicians with AI-driven health care alerts and educational material. Provide seamless, high reach on-demand educational content or targeted in consult decision support for clinicians.

Patient and physician education

Free and easy access to a wide range of high quality and up-to-date fact sheets from Australia's leading health organisations within your clinical management software.

Patient engagement

Assisting patients in making efficient appointment bookings, conducting telehealth appointments, pay and be reimbursed for services securely and efficiently. Digitally connecting patients and carers managing chronic conditions.

Reporting

Transform your practice from the inside out with powerful practice intelligence and analytics tools. Gain valuable insights into your practice and use this data to help improve efficiency, increase billings and improve quality of patient care.

Key features

- Streamline every aspect of a medical practice with a suite of healthcare management tools.
- Tailor clinical IT systems to your needs with a growing partner ecosystem.
- Benefit from seamless onboarding, advanced technology, security and governance, and scalability

Introducing Telstra Health Smart Marketplace – a reimagined suite of healthcare management tools for General Practitioners and Practice Managers.

This all-inclusive ecosystem empowers medical professionals with a comprehensive suite of tools designed to streamline every aspect of their practice.

Manage your practice your way, with tailored solutions from Smart Marketplace. Smart Marketplace offers a growing partner ecosystem that enables you to tailor your clinical IT systems with innovative solutions suited to the unique needs of your practice. Smart Marketplace is comprised of an array of health technology partners who offer the highest standard in innovation, service and reliability.

Each Smart Marketplace partner is handpicked for their proven effectiveness and innovation.

MedicalDirector Care – Introducing MedicalDirector Care Plan

Care plans are an important tool to support patients with chronic health conditions, but they can be complicated and time-consuming. This webinar shows you how MedicalDirector Care is making care plans simple and easy to manage while promoting compliance with Medicare.
Join this webinar to learn:

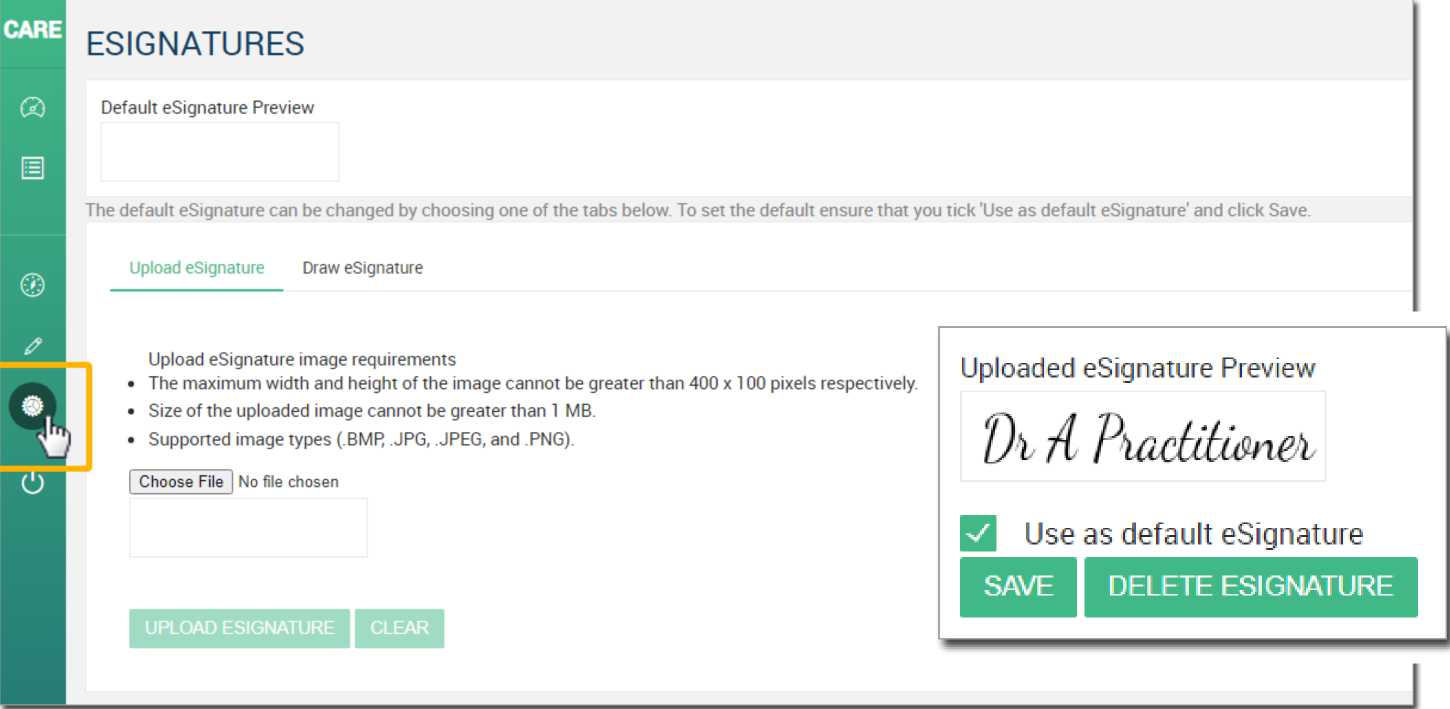
- How care plans benefit patients, practitioners and practices
- How MedicalDirector Care is taking the hassle out of creating, tracking, reviewing and updating care plans
- How to use the templates in MedicalDirector Care to create powerful care plans that will support your patients throughout their healthcare journey.

With MedicalDirector Care at your fingertips, empowering your patients to live their healthiest lives has never been easier. Check out our webinar and you'll soon see why!

MedicalDirector Care – Setup Care Plans

Before you Begin

- o The MedicalDirector Care widget requires MedicalDirector Clinical 3.18 or later.
- o You will need to install the MedicalDirector Care Widget. See Managing Widgets for instructions.
- o You will need to create and save a default eSignature.
- o The MedicalDirector Care widget requires Google Chrome, Microsoft Edge, or Mozilla Firefox



Create an eSignature

•For information about electronic signatures, see Electronic Signatures.
•Note that an electronic signature is only effective if the person receiving it (e.g. a specialist) accepts the signature in that form.

1. Open the MedicalDirector Care widget from the Sidebar and select **User Settings.**

2. Locate and click the eSignatures settings button, as shown below.

o If this is the first time you have created an eSignature, the **Default eSignature Preview** window will be blank, as shown in the example.

3. Select either the **Upload sSignature** tab or the **Draw eSignature** tab to enter a new eSignature.

o The **Upload eSignature** tab allows you to upload an image of a signature that you already have saved on your computer.

o The **Draw eSignature** tab allows you to create a new eSignature, manually, by using your finger or stylus on a touch-screen or tablet.

4. You will be presented with a preview of the eSignature, and prompted to use it as the default. Tick the **Use as Default eSignature** checkbox to confirm.

5. The eSignatures settings window will now display your default selected eSignature. This will be used for all future Care Plans created in MedicalDirector Care, unless you choose to delete it and create a new one. No other configuration is required.

MedicalDirector Care – Create a Care Plans

Obtain consent, review the patient's health summary and choose focus areas. Assign team members and generate documentation.

Overview

1. Obtain the patient's consent.
2.. Assign the primary GP.
3. Discuss and record the patient's overarching goal.
4. Review the patient's health summary.
5. Select a template and choose focus areas.
6. Customise care plan to suit the patient.
7. Set goals, tasks and metrics.
8. Assign team members, generate referrals.
9. Set tracking and billing options.
10. Generate a printed care plan.

MedicalDirector Care is able to create printed care plans.

Care plan - Health summary

CAREPLAN

TO BE REVIEWED 10/09/2018

Horatio Farnswell

PATIENT'S GOAL

I would like to be able to play basketball with my kids again and be able to improve my overall health.

Social History
Retired and living with daughter and her partner. Few social interactions outside of weekly social group.

Family History
Father - AMI 77, Sister diagnosed with Chrones disease at age 55.

CAREPLAN MEMBERS

Dr John Everyman	General Practitioner	0400 000 000
Dr Nicole Everywoman	Dietician	0400 000 000
Dr Nick Notarealastname	Exercise Therapist	0400 000 000
Dr Jeff Coppler	Podiatrist	0400 000 000

MEDICATIONS

Drug name	Directions	Condition/s
ALLOPURINOL Tablet 100mg	1 Daily	Hypertension
ASTRIX Tablet 100mg	1 Daily	Hypercholesterolemia
BICOR Tablet 10mg	1 In the morning	Hypercholesterolemia
CADUET Tablet 5mg/80mg	1 Daily	Hypercholesterolemia
COVERSYL Tablet 10mg	1 In the morning	Hypercholesterolemia
DIABEX XR Tablet 500mg	1 Twice a day	Diabetes Mellitus Type II
EZETROL Tablet 10mg	1 Daily	Diabetes Mellitus Type II
ASTRIX Tablet 100mg	1 Daily	Hypercholesterolemia
BICOR Tablet 10mg	1 In the morning	Hypercholesterolemia

PATIENT DETAILS

Gender
Male

Date of Birth
07/06/1987

Address
1 Fake Road ,Woy Woy, NSW 2256

Phone
+(62) 9000 0000

Mobile
N/A

Medicare Number
0000 00000 0

Allergies
Shellfish, Peanuts , Glucose, Chlorsig, Ibuprofen, Tetracycline

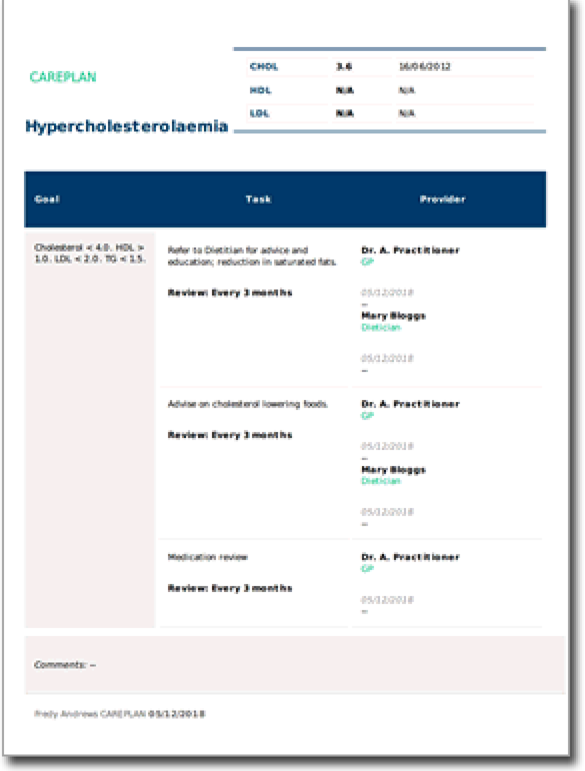
Smoking
Non-Smoker

Alcohol
2-3 drinks per week

CONDITIONS

1992	Diabetes Mellitus - Type II
1995	Hyperlipidaemia
1995	Hypertension
1995	Ischaemic Heart Disease
2004	Frozen Shoulder
2010	Obstructive Sleep Apnoea
2013	Allergic Rhinitis
2013	Ectropion (Bilateral)
2013	LVF (Left Ventricular Failure)

Care plan – Focus areas



CAREPLAN

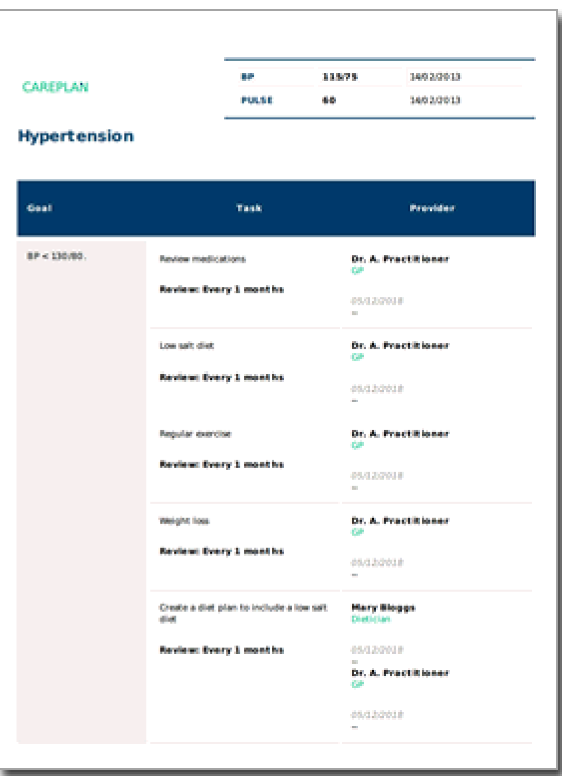
Hypercholesterolaemia

CHOL	3.6	16/06/2012
HDL	N/A	N/A
LDL	N/A	N/A

Goal	Task	Provider
Cholesterol < 4.0. HDL > 1.0. LDL < 2.0. TG < 1.5.	Refer to Dietitian for advice and education; reduction in saturated fats. **Review: Every 3 months**	**Dr. A. Practitioner** GP 05/12/2018 – **Mary Bloggs** Dietician 05/12/2018 –
	Advise on cholesterol lowering foods. **Review: Every 3 months**	**Dr. A. Practitioner** GP 05/12/2018 – **Mary Bloggs** Dietician 05/12/2018 –
	Medication review **Review: Every 3 months**	**Dr. A. Practitioner** GP 05/12/2018 –

Comments: –

Fredy Andrews CAREPLAN 05/12/2018



CAREPLAN

Hypertension

BP	115/75	14/02/2013
PULSE	60	14/02/2013

Goal	Task	Provider
BP < 130/80.	Review medications **Review: Every 1 months**	**Dr. A. Practitioner** GP 05/12/2018 –
	Low salt diet **Review: Every 1 months**	**Dr. A. Practitioner** GP 05/12/2018 –
	Regular exercise **Review: Every 1 months**	**Dr. A. Practitioner** GP 05/12/2018 –
	Weight loss **Review: Every 1 months**	**Dr. A. Practitioner** GP 05/12/2018 –
	Create a diet plan to include a low salt diet **Review: Every 1 months**	**Mary Bloggs** Dietician 05/12/2018 – **Dr. A. Practitioner** GP 05/12/2018 –

MedicalDirector Care – Create a Care Plans

Launch a care plan, obtain patient consent and discuss the patient's overarching health goal

1. From within the patient's record, open the MedicalDirector Care widget from the Sidebar and choose **Create Care Plan.**

2. Gain the patient's consent to create a care plan.

3. Click create button o You may be required to log into the MD Care site.

o The **Care Plan Setup** will commence.

4. You will be presented with the **Patient Consent** window where you can review the conditions of consent.

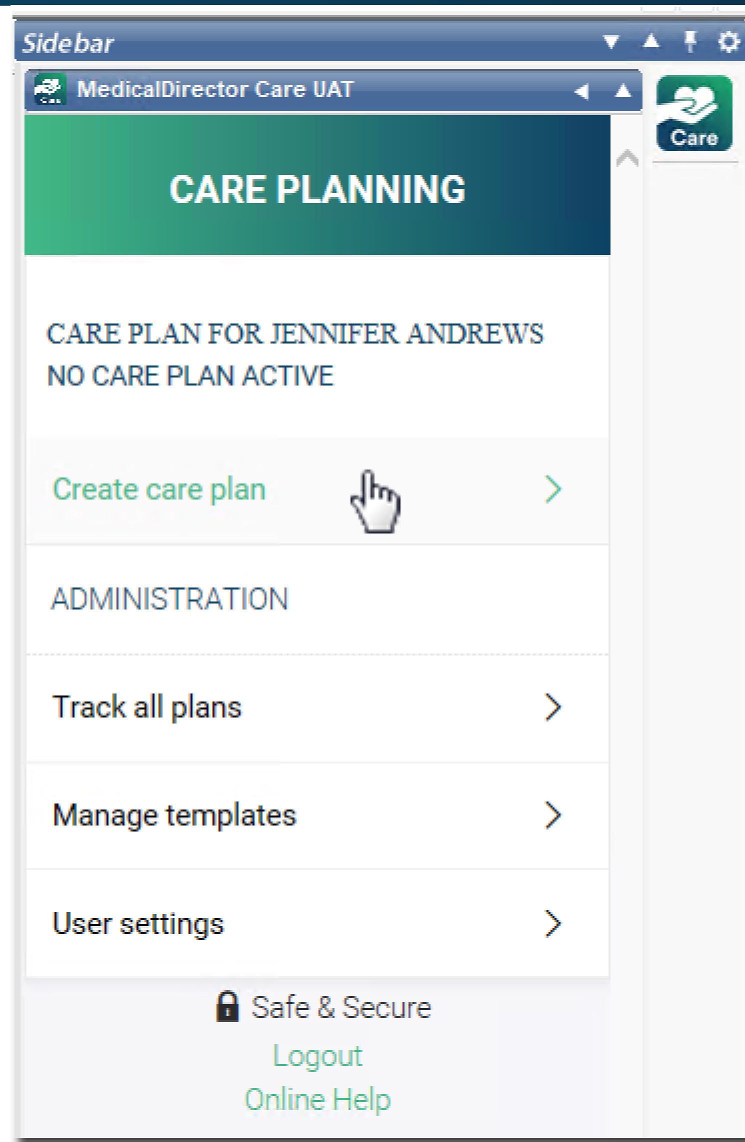
o This step can be skipped and recorded later in the patient dashboard.

5. Click **Select Primary GP>** button to continue.

o On the **Select Primary GP** window, accept the default healthcare professional selected or choose another.

6. Click the associated **Goal** button to continue. You are presented with an opportunity to record the patient's goal, in their words.

7. **Click Health Summary >** button Review the patient's health summary, select a template and choose focus areas.



o All data appearing in the Health Summary is taken directly from MedicalDirector Clinical. As such, MedicalDirector Clinical remains the source of truth for the care plan. If data needs to be corrected, correct it in Clinical and relaunch the care plan. Review Conditions (past medical history), Medications, Allergies, Immunisations, Family History and Social History. Ensure the data is correct and is suitable for sharing with team members outside the practice. Use the check boxes to decide what will (and won't) be shown on the care plan.

o The data chosen in the previous screens all make up the patient summary part of the care plan, including:

- The patient's goal.
- Social and family history.
- Patient demographic details.
- Medications.
- Conditions (Past medical history).

8. After navigating the patient's Health Summary and making modifications as required, click **Plan Details >** button to choose a plan template that suits this patient.

o The **Supplied** tab on this window contains supplied templates.

o Supplied templates can be **modified** to suit your practice's needs. **Modified** templates appear in the **Customised** tab.

9. Select a plan to customise.
10. Click **Create Plan>** button to create the care plan.

MedicalDirector Care – Create a Care Plans

11. You can set goals, tasks and metrics for each focus area.

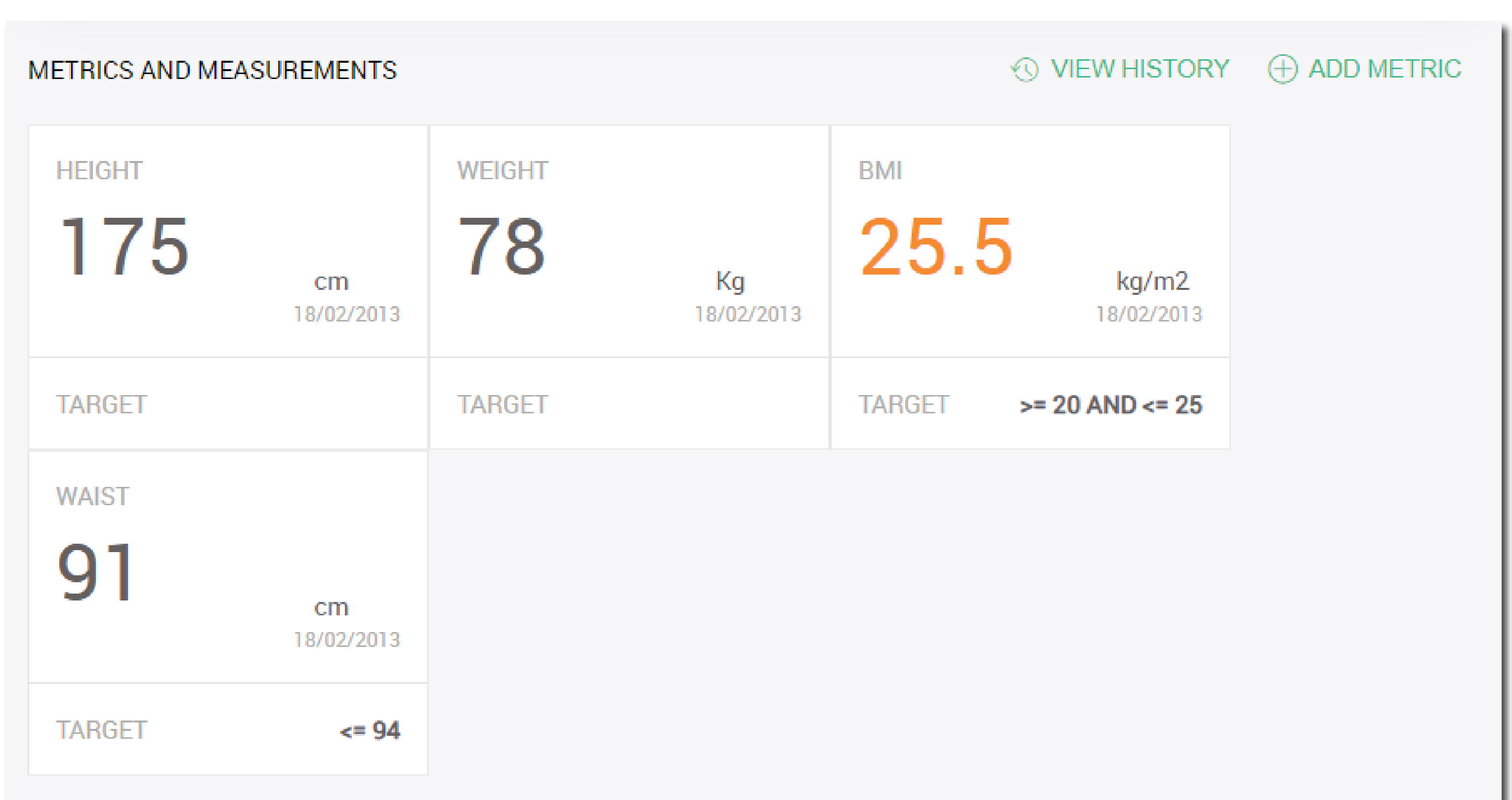
- o Health summary pages.
- o Focus areas pages.
- o Care plan.
- o Roles and team members & team member documentation.
- o Admin tasks (billing and reminders).
- o Finalise and generate the care plan document.
- o Timeline of all consult notes, correspondence, pathology and imaging results for this patient.
- o Goal progress.
- o Clinical goals for the patient.
- o Automatically pre-fills latest metrics and measurements retrieved from MedicalDirector Clinical, minimising data entry errors.

12. Review and edit patient clinical goals if required.

MedicalDirector Care – Create a Care Plans

13. Review and edit patient metrics if required.

- The metrics are pre-defined as part of a template.
- For each metric selected, all available measurements will be automatically imported from MedicalDirector Clinical.
- Only the most recent measurements are shown here. To see older measurements click **View History**.
- To add a new metric, click **Add Metric**.



MedicalDirector Care – Create a Care Plans

14. Review and edit tasks if required.

- Competed tasks will show in the Completed view.
- Task descriptions can be changed, roles added or removed and the duration and due dates can be set (if required).
- There are two default roles; GP and Patient.
- Tasks can be assigned more than one role. Assign roles to providers in the Team Members page.

TASKS & CORRESPONDENCE
ADD TASK
Tasks | Team Correspondence
Unassigned roles - Click here to assign team members to roles.
PENDING | COMPLETED

DESCRIPTION	HOW OFTEN	DUE	PROVIDER	COMPLETE
Lifestyle modifications as advised by Dietician and Exercise Physiologist.	Every 6 months	01/04/2021	Dietician, Exercise Physiologist, GP	
Maintain your weight /prevent weight gain by eating healthy and doing at least 30 minutes of physical activity on most days.			Patient	

Edit
Delete

Add/Edit Task

TASK DESCRIPTION
Lifestyle modifications as advised by Dietician and Exercise Physiologist.
For patient tasks, avoid jargon and abbreviations. Be specific with the tasks e.g. "Excercise at least 20 mins a day, 5 days a week."

PROVIDERS
Dietician × | Exercise Physiologist × | GP ×
Search and add one or more roles that will be responsible for this task (includes "Patient" and "GP")

HOW OFTEN
ONGOING | RECURRING | ONCE
Review Every | Interval 6 | months | from now

CANCEL | SAVE

MedicalDirector Care – Create a Care Plans

15. Assign team members and generate referrals.

    1. Via the **Team Members** list located in the left-hand margin of this window, select the type of healthcare professional you wish to assign to the care plan. In the example below, we have selected Physiotherapist.
        - The Team Members list is dynamic, based on the roles you assigned to the various tasks of the care plan.
        - The list of available healthcare professionals/providers is drawn from the MedicalDirector Clinical Address Book.

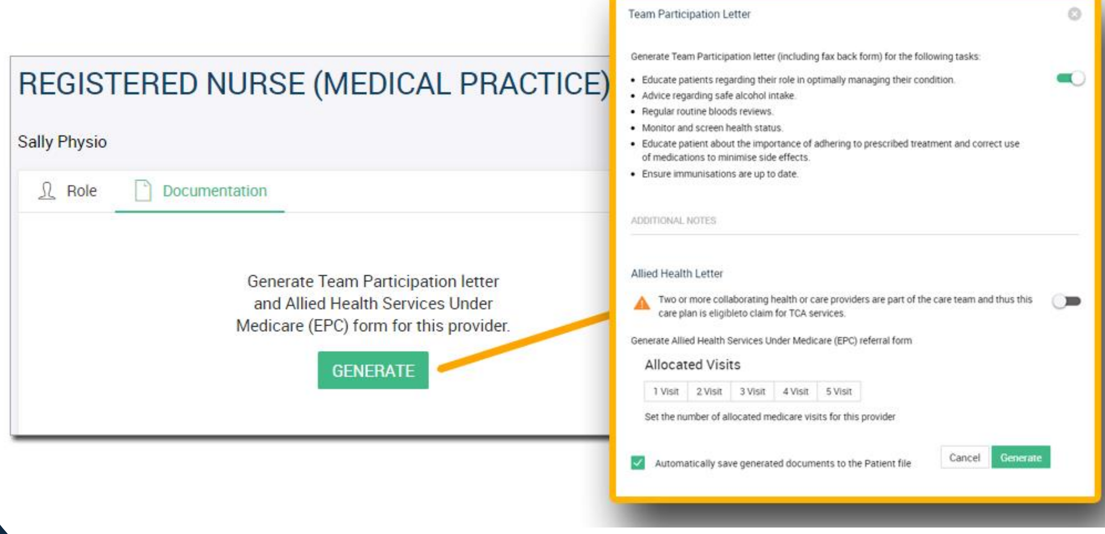
15b. Click Assign Provider to locate and select a healthcare provider of the type you wish to add to your team.

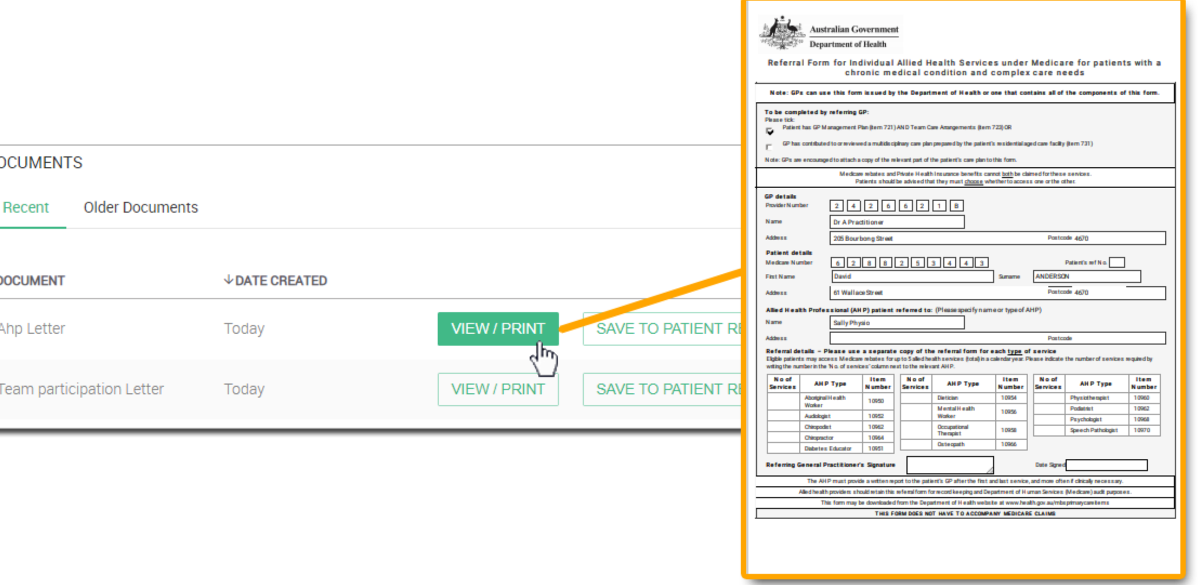
- Click **Assign** button against the provider you wish to select.

You will be returned to the Team Members page where your selected provider now appears.

MedicalDirector Care – Create a Care Plans

16. Optionally generate a Team Participation letter and an Allied Health Referral letter. Select the **Documentation** tab and click **Generate** button



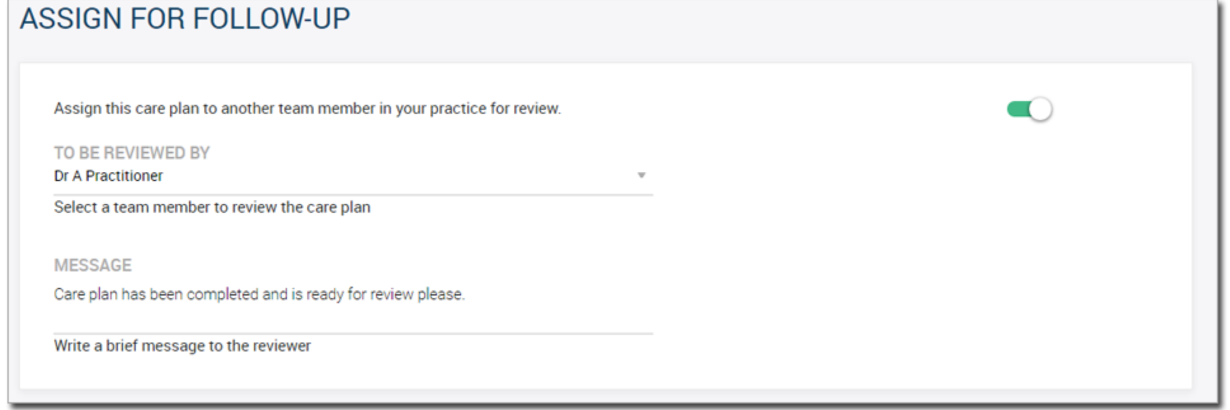


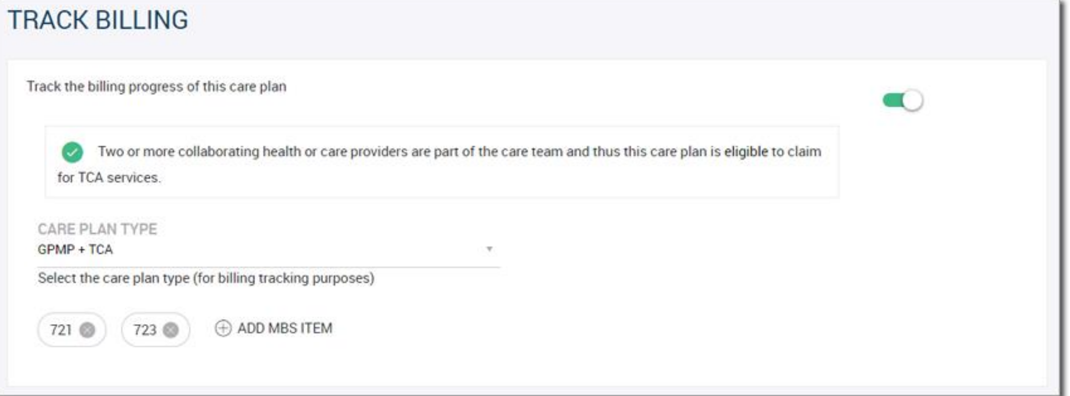
17. Optionally view/print an Allied Health Services referral letter and/or Team Participation letter.

MedicalDirector Care – Create a Care Plans

18. Set tracking and billing options.

- Assign to another member of the practice to review once the care plan has been finished (optional).
- Set the care plan type (optional). Each type has pre-set expected MBS item code(s). These are tracked on the patient and practice dashboards, using billing data extracted from Pracsoft.
- Set the review period which will control when the next review for the care plan is due (optional). Upcoming and overdue care plans show in the practice dashboard.



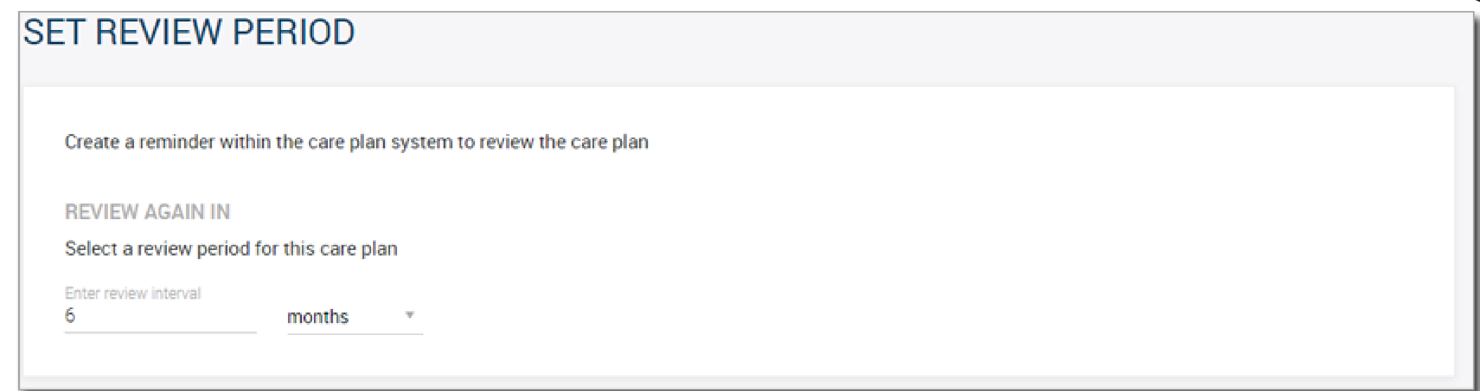


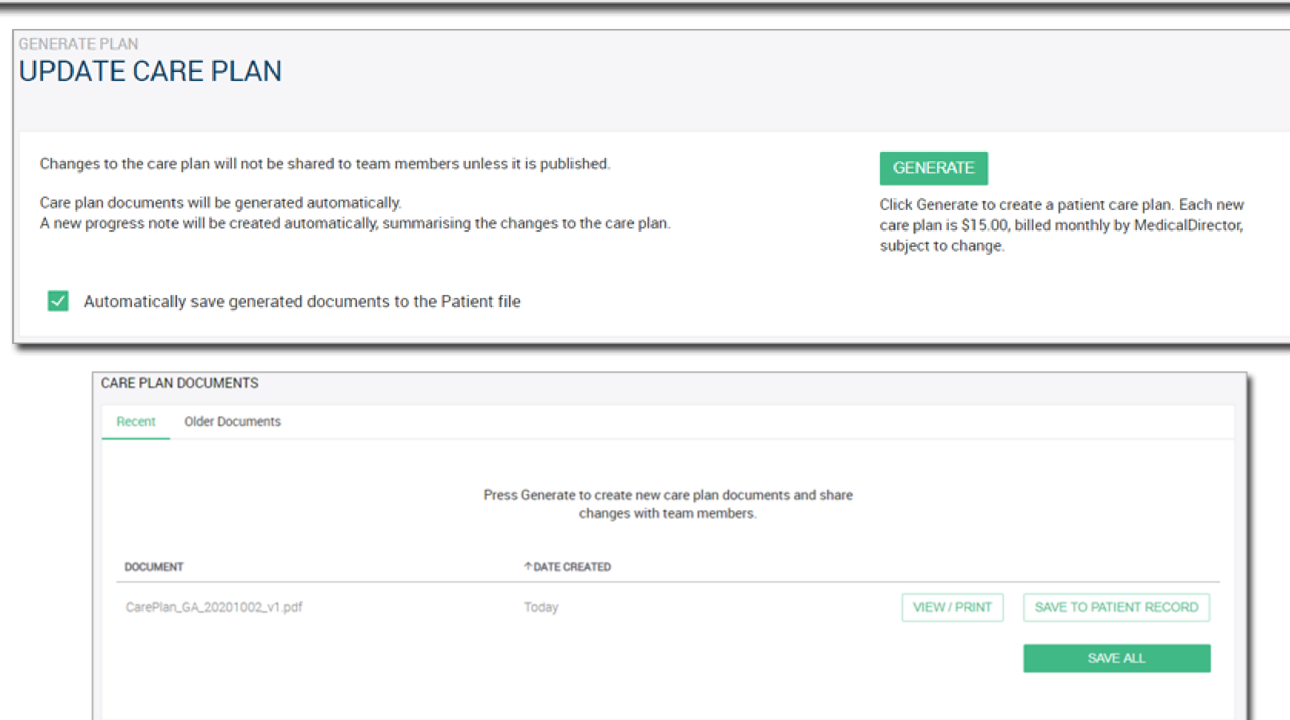
MedicalDirector Care –Create a Care Plans

19. Generate a printed care plan.

o Finalise the care plan and generate the care plan document. The care plan will automatically be saved to MedicalDirector Clinical.

o View or print the generated care plan and (optionally) save to the patient record it if has not been previously saved. The goals, metrics, tasks and correspondence shown in the previous screens are used to create the printed version of the care plan.





MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

MedicalDirector Care comes provided with a variety of care plan templates, and you can create your own by using one of the supplied templates as a base. The following instructions cover creating new templates and can assist with editing templates you have already created.

1. From the MedicalDirector Care widget, select **Manage Templates**.

2. The **Template Management** window appears. By default, you are presented with the **Supplied** tab as shown in the example below. The **Customised** tab is where your customised templates will appear once you have created one. To create your first customised template, you must first select a supplied template to base it on. In our example, we are going to select the **Multidisciplinary Care Plan** template as shown in the example below.

CARE PLANNING
ADMINISTRATION
Track all plans
Manage templates
User settings

CARE
TEMPLATE MANAGEMENT
SELECT A TEMPLATE
Supplied
Customised
Multidisciplinary Care Plan
Concise care plan for multiple chronic conditions.

MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

3. After selecting a base for your new template, you will be presented with a list of patient problems, needs and conditions to choose from which can be added to your *new* template.

•Select 1 or more items to add to your new template.

•You can rename as existing item by clicking its associate button.

•You can create a new item by clicking ⊕ Patient problem, need or relevant condition

4. In our example, we have selected 'Recurrent Skin Cancer Risk'. Select at least one item to add to your new template, and click **Edit Template** button.

Selected template: Multidisciplinary Care Plan

Supplied Customised

CHOOSE PATIENT PROBLEMS, NEEDS OR RELEVANT CONDITIONS

☐ Osteoarthritis

☐ Osteoporosis

☑ Recurrent Skin Cancer Risk

⊕ Patient problem, need or relevant condition

< SELECT A TEMPLATE | EDIT TEMPLATE >

MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

5. You will be presented with the details of your first selected item. In our example, it's the Recurrent Skin Cancer Risk item.

TEMPLATE MANAGEMENT | MULTIDISCIPLINARY CARE PLAN

BACK

SAVE TEMPLATE

PATIENT PROBLEMS, NEEDS OR RELEVANT CONDITIONS

MULTIDISCIPLINARY CARE PLAN

Obesity

Recurrent Skin Cancer Risk

PATIENT PROBLEMS, NEEDS OR RELEVANT CONDITIONS

RECURRENT SKIN CANCER RISK

GOALS

Skin Cancer

GOAL PROGRESS

REMOVE GOAL

GOALS AND HEALTH NEEDS

Early detection and Treatment

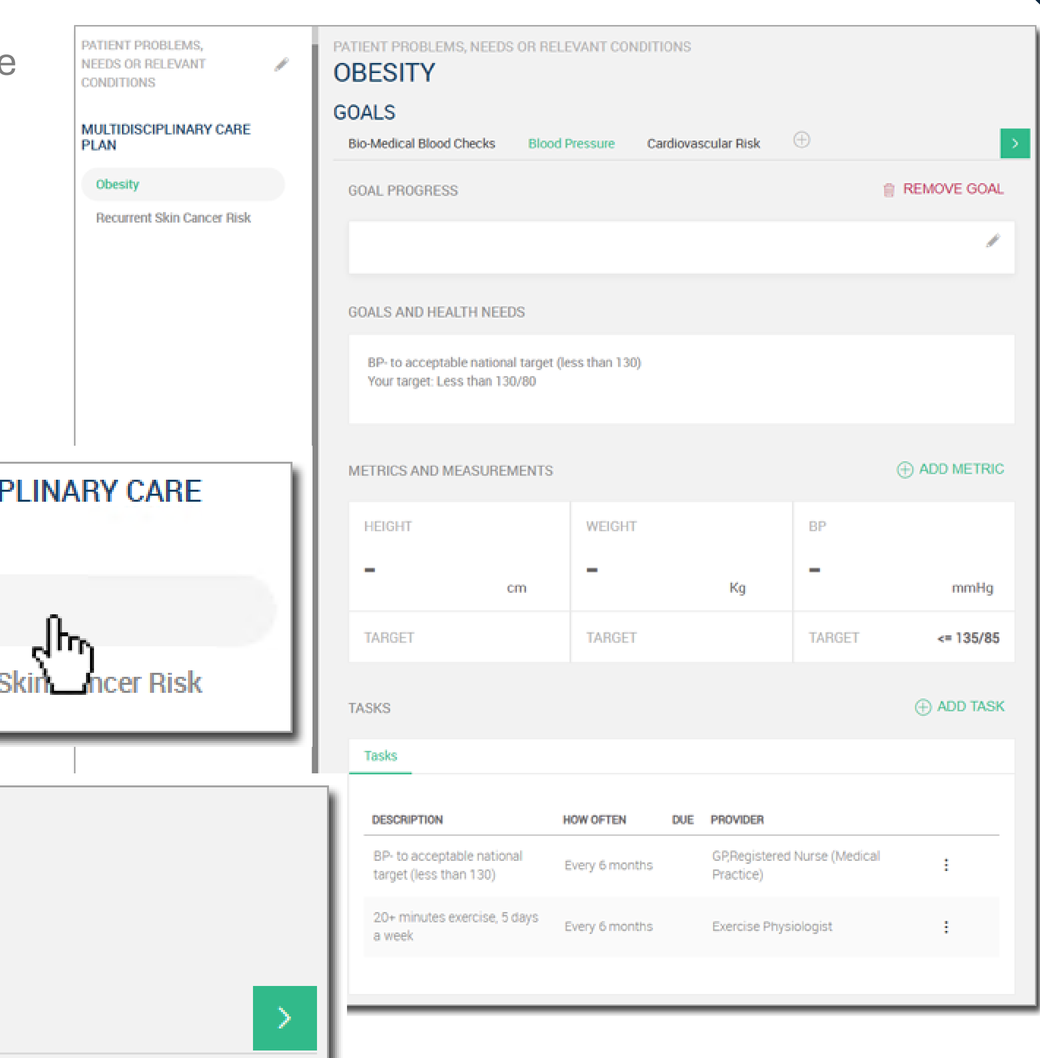
MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

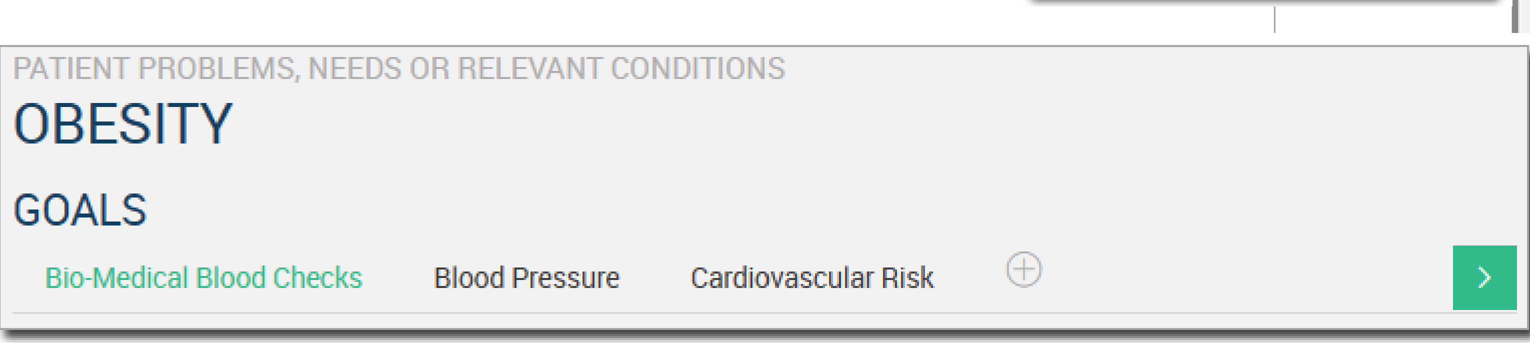
6. If you have selected multiple items to edit, you can toggle between them via the panel on the left of the window. In the following example we want to edit our Obesity plan details, so we select it here.

7. At the top of the window, you are presented with the various goals associated with the item you selected. The example below shows our Obesity item and 3 goals we have associated with it: Bio-Medical Blood Checks, Blood Pressure, and Cardiovascular Risk.

   - Add a goal by clicking
   - Switch between goals by clicking the title.

8. Under each goal are associated Progress, Health Needs, Metrics and Measurements, and Tasks.





MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

9. You can edit each section of the goal. For example, to add a new metric, click

⊕ ADD METRIC

10. Similarly, you can insert additional tasks, click

⊕ ADD TASK

11. When you have finished editing the template, click **Save Template** button located at the top-right of the editing window.

Add/Edit Task

TASK DESCRIPTION

20+ minutes exercise, 5 days a week

PROVIDERS

Exercise Physiologist ×

Search and add one or more roles that will be responsible for this task (includes "Patient" and "UP")

HOW OFTEN

ONGOING | RECURRING | ONCE

Review Every Interval 6 months from now

CANCEL SAVE

METRICS

SEARCH FOR METRICS

UNITS OF MEASURE

TARGET VALUE

CANCEL SAVE

MedicalDirector Care – Create or Edit a Care Plan Template Care Plans

12. You will be prompted to name the new template, and optionally give it a description.

13. Click **Save** button to save your customised template. Your new template now appears within the Customised list.

CARE

TEMPLATE MANAGEMENT

SELECT A TEMPLATE

Supplied Customised

Coronary Heart Disease
New Coronary Heart Disease Template
Last Edited 08/09/2022

My Template
New Template
Last Edited 03/07/2023

Save Custom Care Plan Template

Save Changes to an Existing Template

Multidisciplinary Care Plan
Concise care plan for multiple chronic conditions.

Create a New Custom Template

TEMPLATE NAME
My Template

TEMPLATE DESCRIPTION
New Template
Provide a description for this template

CANCEL SAVE

MedicalDirector Care – Review a Care Plans

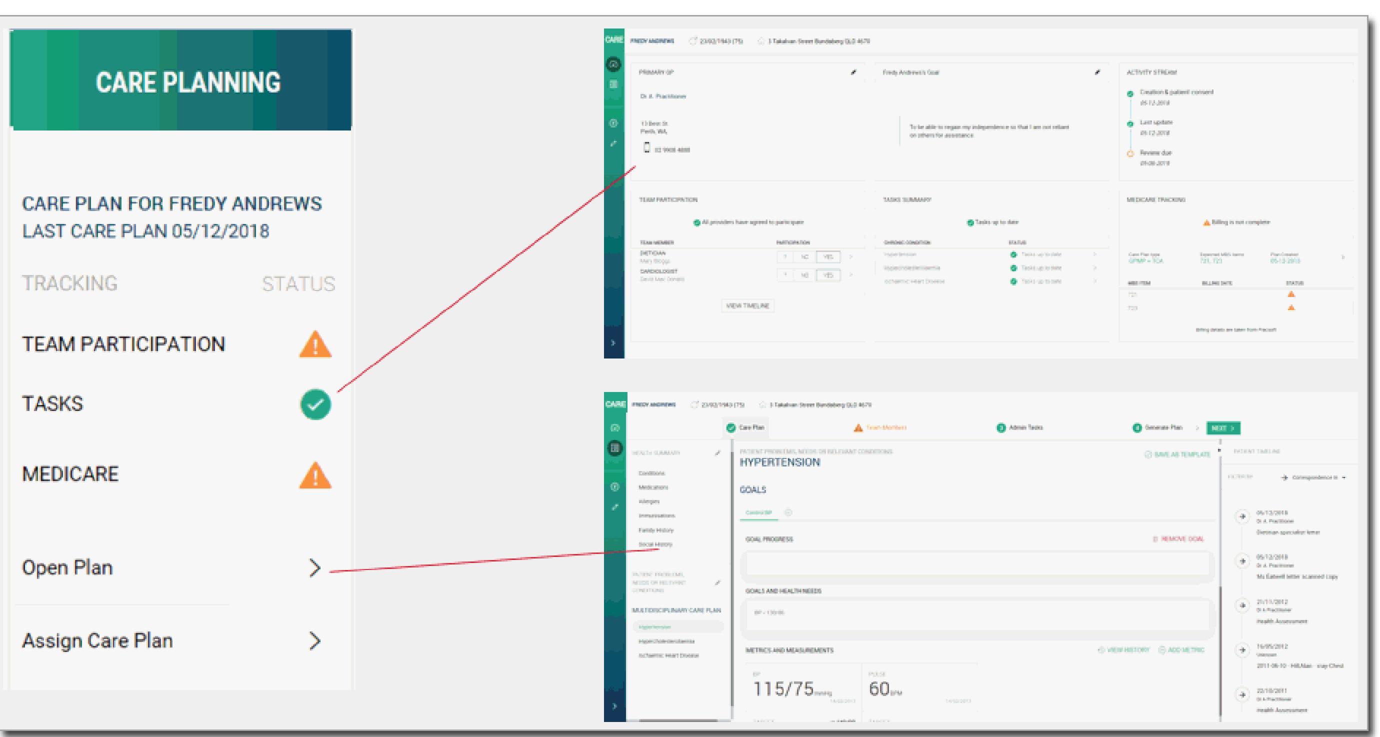
Overview

1. Review correspondence, pathology and imaging results since the last care plan.

2. Record the patient's progress and track due tasks.

3. Review the team members and generate any required documentation.

4. Set tracking and billing options. Generate a printed care plan, if required.



Step-by-Step

1. Review correspondence, pathology and imaging results since the last care plan.

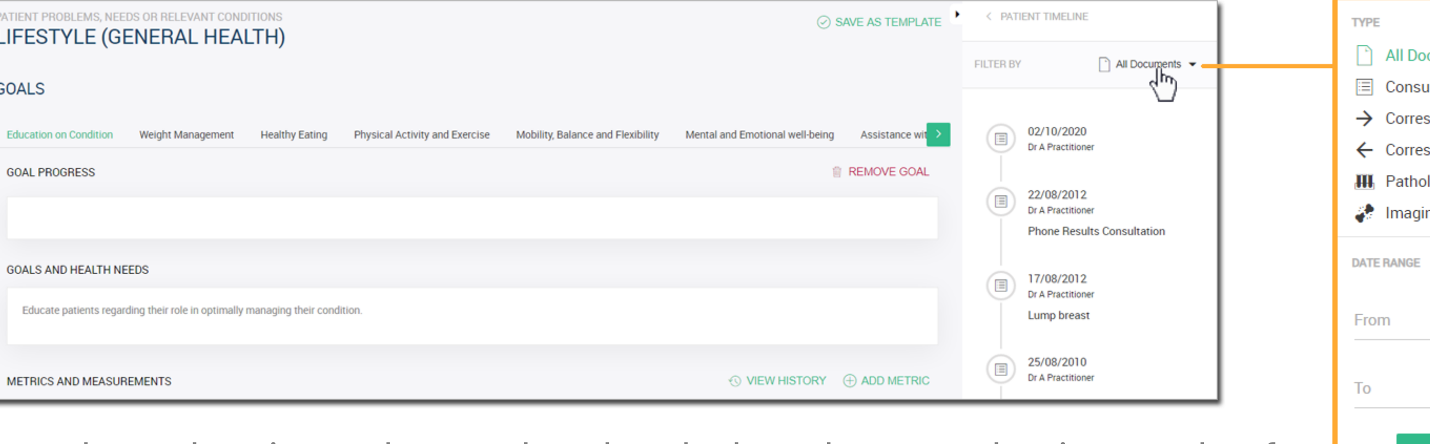
- Open a patient's care plan by clicking on the tracking summary part of the widget or by clicking Open Plan.

MedicalDirector Care – Review a Care Plans

o View summary details about the care plan with the patient dashboard.

The patient dashboard provides a summary view of the care plan including:

- Primary GP.
- Patient demographic details.
- The patient's overarching goal.



- Critical dates including the date of the first care plan, when it was last updated and when the care plan is next due for review.
- Team member participation status.
- Tasks status.
- Billing status.

o The patient timeline represents all the documents which are stored in MedicalDirector Clinical for this patient.

- You can filter by document type or change the date range, to limit the amount of documents shown. Note: the From Date filter will automatically populate with the date of the last care plan to ensure that only the documents which were created since the last care plan are shown.

MedicalDirector Care – Review a Care Plans

Document navigation:

Hide/Show Document Panel

Return to the Patient Timeline

Skip to next/previous document

Click to display a document

Expand

1

Wednesday August 22 2012 11:35:04
Dr A Practitioner

Phone consultation after results returned from Lab.

Discussed results. Patient will keep an eye on the lump and come back if it changes

Reason for contact:
Phone Results Consultation

Actions:
Result notified by Dr A Practitioner - PAP SMEAR 17/08/2012
Result notified by Dr A Practitioner - CYTOLOGY NON-GYNAE 17/08/2012
Result notified by Dr A Practitioner - MASTER IRON STUDIES 17/08/2012
Result notified by Dr A Practitioner - MASTER FULL BLOOD COUNT 17/08/2012
Result notified by Dr A Practitioner - E/LFT (MASTER) 17/08/2012
Removed recall for PAP SMEAR on 20/08/2012.

PATIENT TIMELINE

22/08/2012
Consult Notes Results
Phone Results Consultation

PRACTITIONER
Dr A Practitioner

LINK DOCUMENT

Assigned Tasks

PATIENT TIMELINE

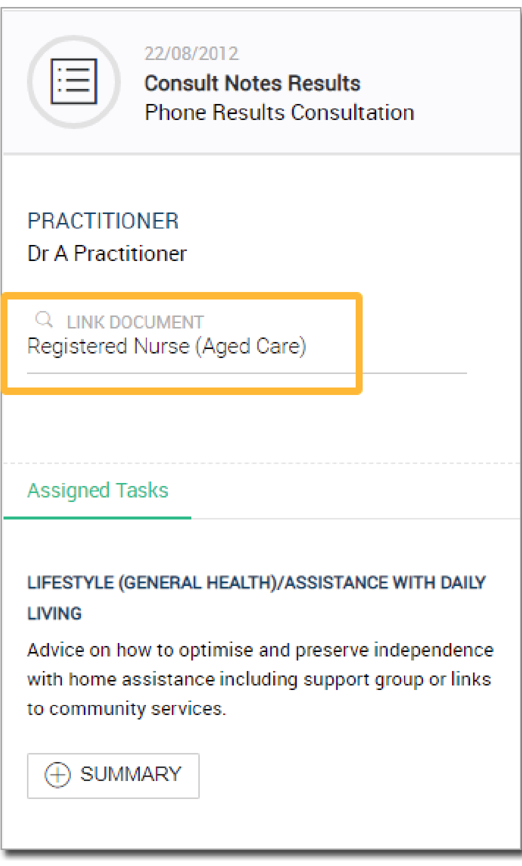
FILTER BY All Documents

02/10/2020
Dr A Practitioner

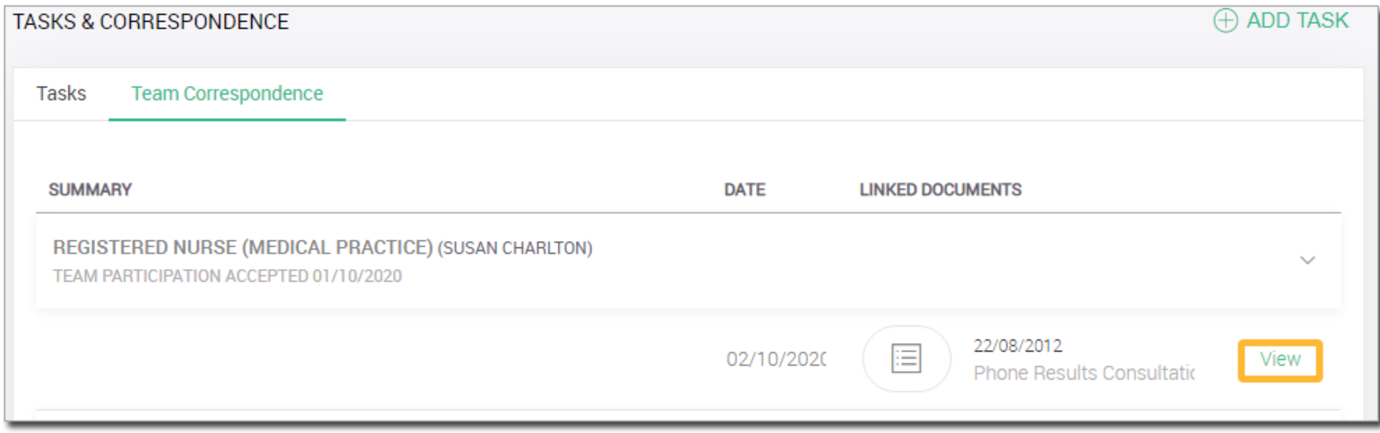
22/08/2012
Dr A Practitioner
Phone Results Consultation

MedicalDirector Care – Review a Care Plans

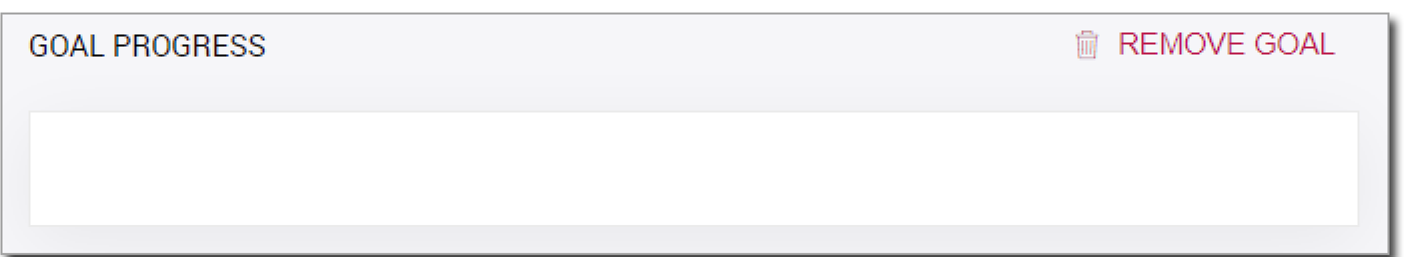
- You can link the team member who authored the document (or role) and then provide a summary of their correspondence.



- Linked documents (with summary) show in the Team Correspondence tab. Click **View** to view the original document.



2. **Update progress notes and review tasks.**
   - Record progress notes for this focus area here.



MedicalDirector Care – Review a Care Plans

TASKS & CORRESPONDENCE

ADD TASK

Tasks | Team Correspondence

PENDING | COMPLETED

DESCRIPTION	HOW OFTEN	DUE	PROVIDER	COMPLETE
Educate patients regarding their role in optimally managing their condition.	Every 12 months	02/10/2021	GP, Registered Nurse (Medical Practice)	☐
Know how to optimally monitor and manage your condition.	Every 12 months	02/10/2021	Patient	☐

- Mark as complete any tasks which have been done and add any new tasks which should be done on an ongoing basis, should be done by a specific date or tasks which should be reviewed periodically to measure progress.
- Tasks which have been marked as complete show in the Completed view.

MedicalDirector Care – Review a Care Plans

3. **Check team members status, track the plan and set review dates, generate documentation.**

- Review and update team members.

- If needed, generate new referrals or team participation letters.

TEAM MEMBERS

REGISTERED NURSE (MEDICAL PRACTICE)
Susan CHARLTON

DIETICIAN
Unassigned

EXERCISE PHYSIOLOGIST
Unassigned

OCCUPATIONAL THERAPIST
Unassigned

OSTEOPATH
Unassigned

PHYSIOTHERAPIST
Unassigned

PHYSIOTHERAPIST

Unassigned

Role | Documentation

Assign Provider

Click documentation tab for generating team participation letter and referral form.

TEAM MEMBERS

REGISTERED NURSE (MEDICAL PRACTICE)
Susan CHARLTON

DIETICIAN
Unassigned

EXERCISE PHYSIOLOGIST
Unassigned

OCCUPATIONAL THERAPIST
Unassigned

OSTEOPATH
Unassigned

PHYSIOTHERAPIST
Paul SHEPHERD

PSYCHOLOGIST

PHYSIOTHERAPIST

Paul SHEPHERD

Role | Documentation

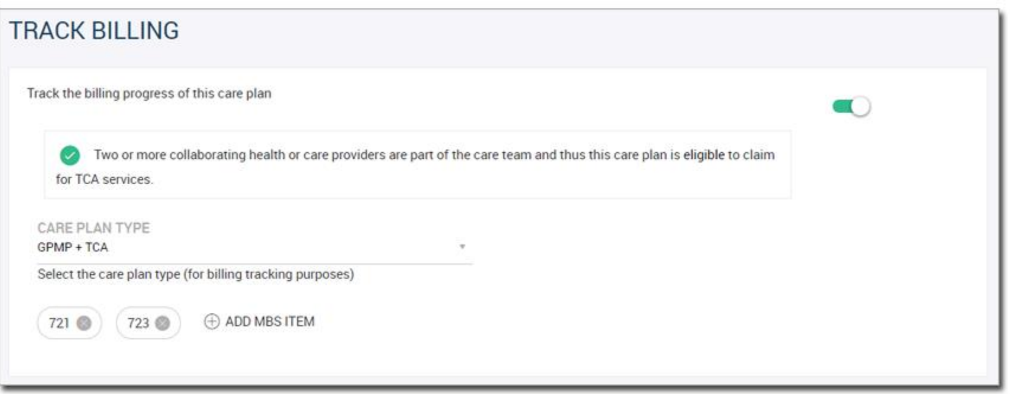
Generate Team Participation letter and Allied Health Services Under Medicare (EPC) form for this provider.

GENERATE

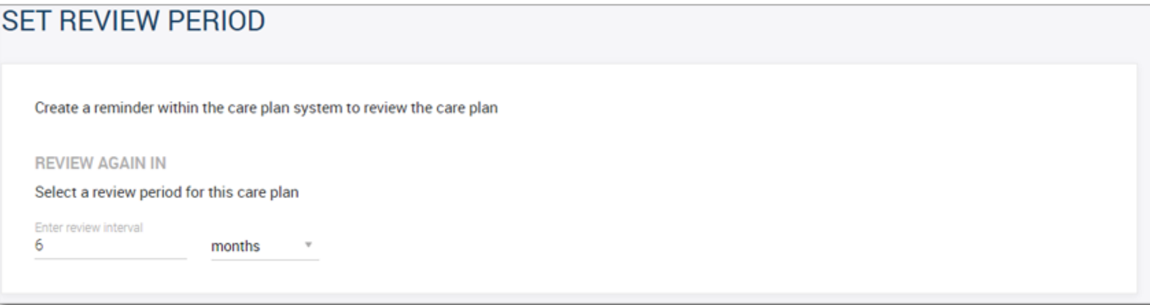
DOCUMENTS

MedicalDirector Care – Review a Care Plans

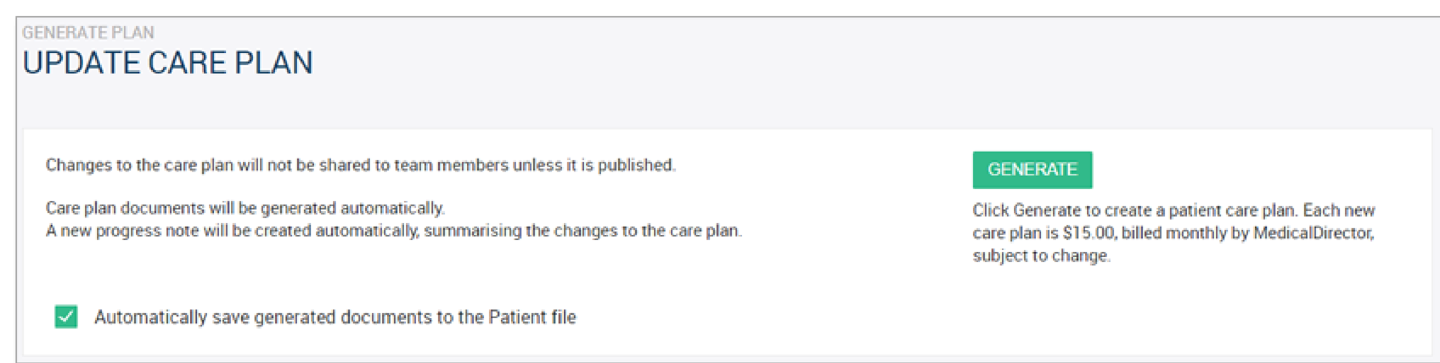
- Track this plan to ensure it is billed.



- Set an interval for the next review.



- Generate the care plan for your records.

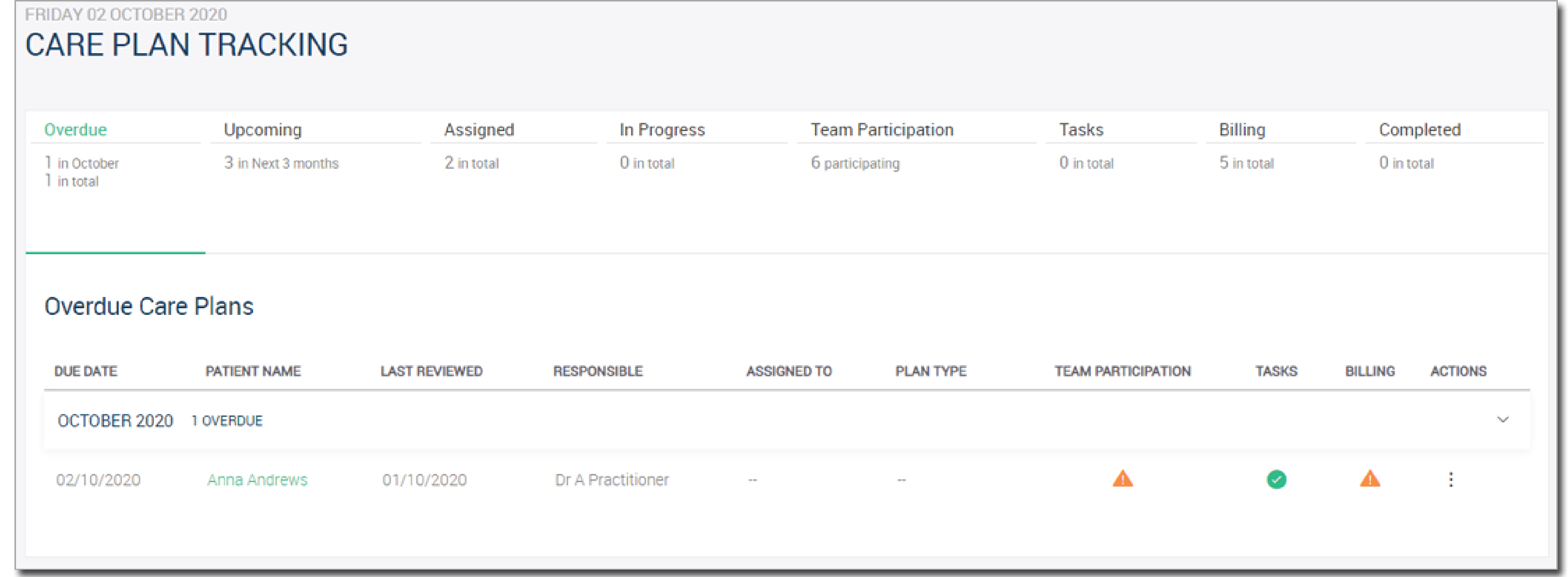


MedicalDirector Care – Track Care Plans

- Review upcoming, overdue and in-progress care plans.
- Ensure the correct billing has been done in a timely manner.

The practice dashboard tracks all care plans. The practice dashboard will track all care plans that:

- Are overdue.
- Are coming up for review.
- Have been assigned to a user in the practice.
- Have been started but not yet finalised.
- Are awaiting on all team members to agree to participate.
- Have not been fully billed.
- Are complete, with no outstanding issues.



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P: (03) 9046 0300

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Upcoming Webinar

MedicalDirector Training for Advanced Practice Managers

EMPHN is offering FREE MedicalDirector Training for Practice Managers.

Dates: Time: Location: Enquiries:
Thursday 8 August 2024 12pm - 2pm
Online webinar Digital Health
digitalhealth@emphn.org.au

This is a great opportunity for new Practice Managers and current Practice Managers to update or refresh your skills.

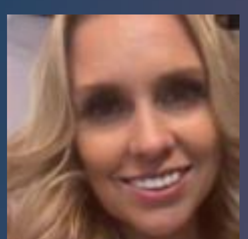
The Training will be delivered remotely by Medical Director Trainers and will cover the following:

- Data Quality and Data Cleansing
- 4.3 Enhancements
- Template Management
- Sending Emails
- My Health Record - NASH - Setup requirements
- Patient Search Utility
- MD Utilities
- Setting up permissions and configuring users
- Managing the appointment types

Register using the QR code or visit
www.emphn.org.au/newsevents/events/detail/25924

Thank you

A recording & slides of this session and feedback form will be delivered to your inbox shortly.



Kylie Goodwin
Practice Consultant
MedicalDirector | Telstra Health