MedicalDirector Clinical Training for GPs

Grant Smith
Kylie Goodwin
Barb Repcen

MedicalDirector | Health Primary, Aged & Community Care

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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.

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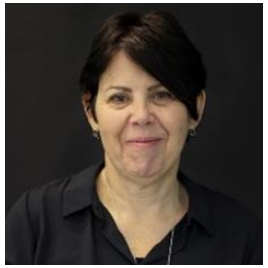
Agenda

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

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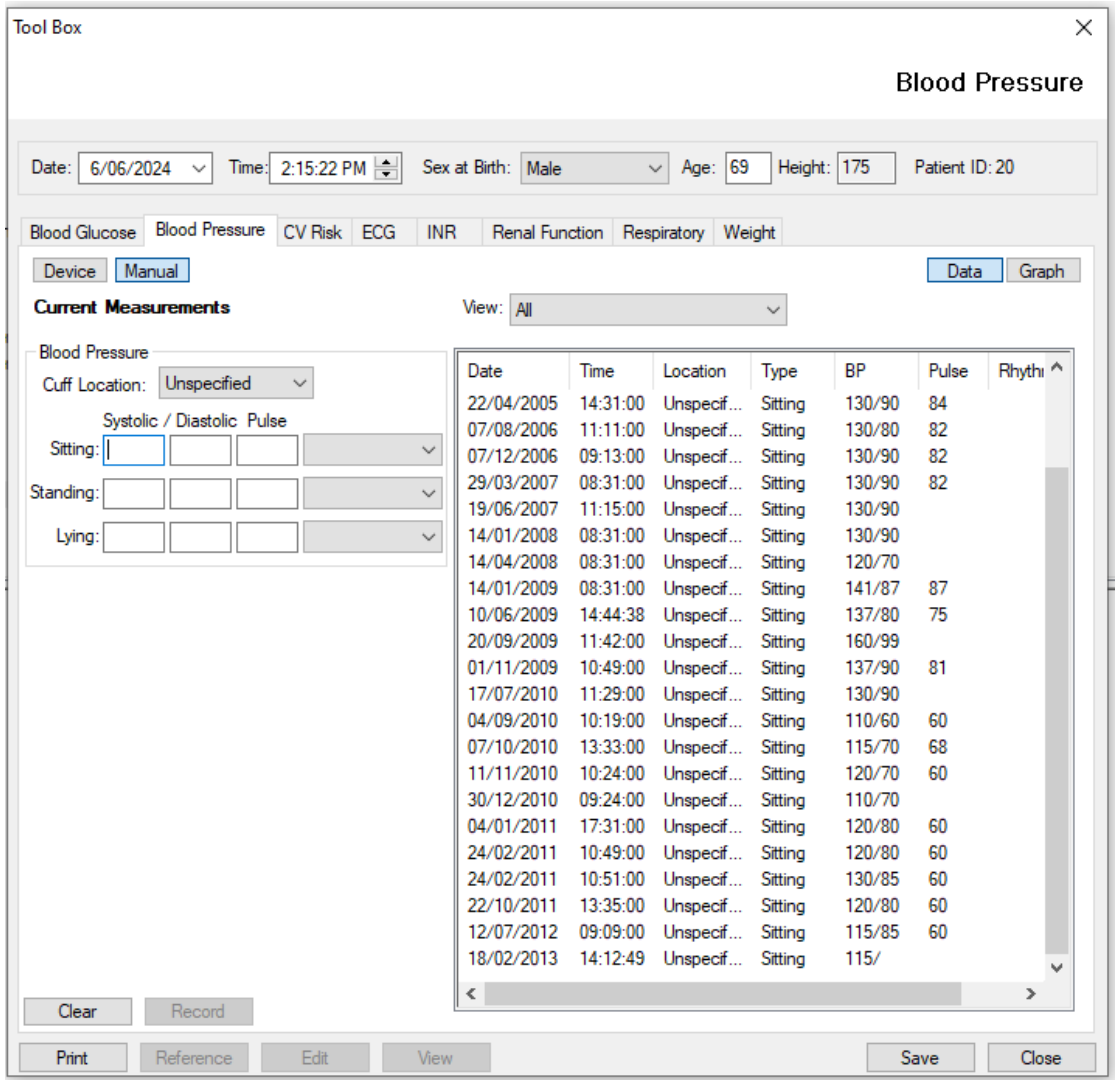
Data Quality using coded lists, recording measures

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

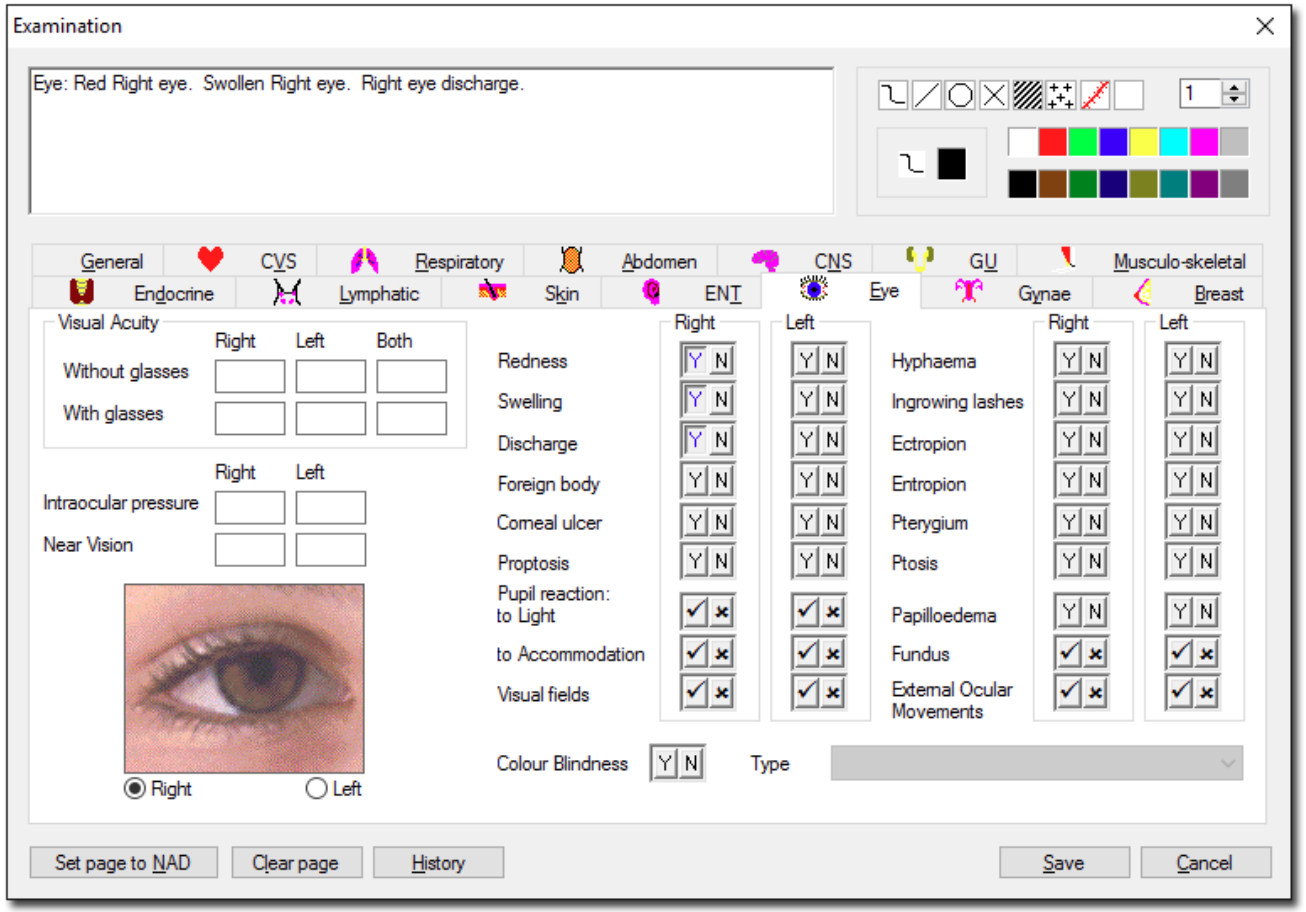
Data Quality using coded lists, recording measures via Progress Notes

The Examination module of Progress Notes allows you to record the findings of a single consultation. Each tab within the Examination module contains a variety of controls for recording information, as shown in the following image.

Some data may also be appear automatically on this window, if it was recorded previously using other components of Clinical, such as the Blood Pressure module.

Information recorded using any of the tools within the Examination module appears in the text box at the upper-left of the window, and upon saving is added to the Progress Note for the consultation.

The content available to this module differs depending on the patient's recorded sex at birth.



CVD (Cardiovascular Risk Calculator) Absolute Calculator

1. From within the Clinical Window, select **Tools > Tool Box > Cardiovascular Risk**. The **CV Risk** tab appears. Select which calculator you wish to use. If you select the Absolute calculator, the following fields will be pre-populated with data, where available:

- **Sex at Birth**. As sourced from the patient's record.
- **Age**. As sourced from the patient's record.
- **Systolic blood pressure**. As sourced from the most recent blood pressure 'sitting' data, recorded within the last 2 months.
- **Diastolic blood pressure**. As sourced from the most recent blood pressure 'sitting' data, recorded within the last 2 months.
- **Smoking status**. A patient who has quit smoking within the last year will be considered a smoker for the purposes of the calculator.
- **Total Cholesterol**. As sourced from the most recent Total Cholesterol data, recorded within the last 2 months.
- **HDL Cholesterol. As sourced from the most recent HDL Cholesterol data, recorded within the last 2 months.**
- **Diabetes. As sourced from the patients past medical history, see Absolute CVD Risk Diagnosis Descriptions.**

2. Options:

- For patients who are automatically considered 'high risk', simply click **Save** button to automatically document the risk value as >15% in the Tool Box. This will also add a note to the patient's Progress Notes. There are no further actions required. You may exit the Tool Box.
- For all other patients, click Absolute CVD Risk Calculator button. Proceed now to Step 3.

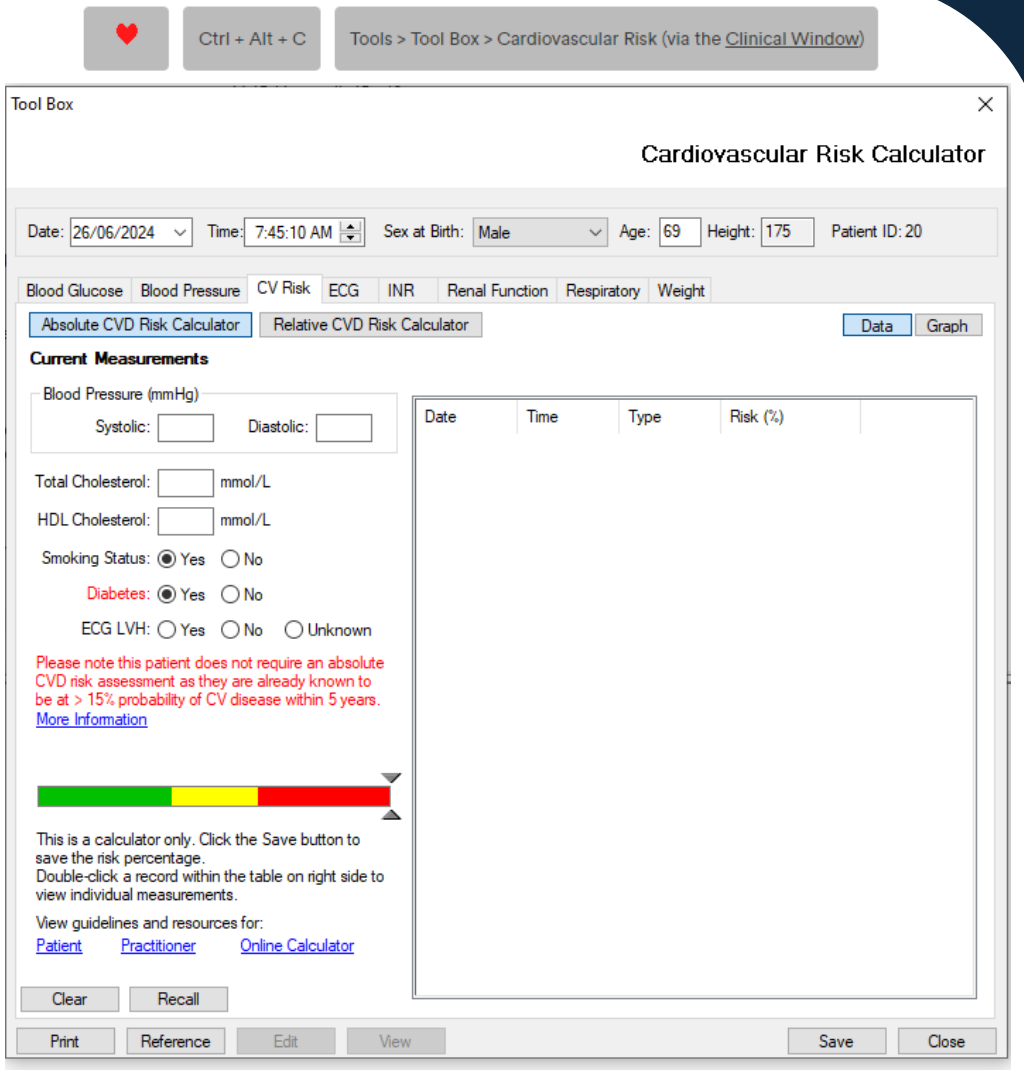
3. Enter values for the following fields:

- Systolic Blood Pressure - (Enter a value between 50 and 300).
- Diastolic Blood Pressure - (Enter a value between 20 and 150).
- Total Cholesterol - (Enter a value between 2 and 30).
- HDL Cholesterol - (Enter a value between 0.2 and 20).

- **Low risk:** Less than 10% probability of cardiovascular disease within the next 5 years.
- **Moderate risk:** 10–15% risk of cardiovascular disease within the next 5 years.
- **High risk:** Greater than 15% risk of cardiovascular disease within the next 5 years.

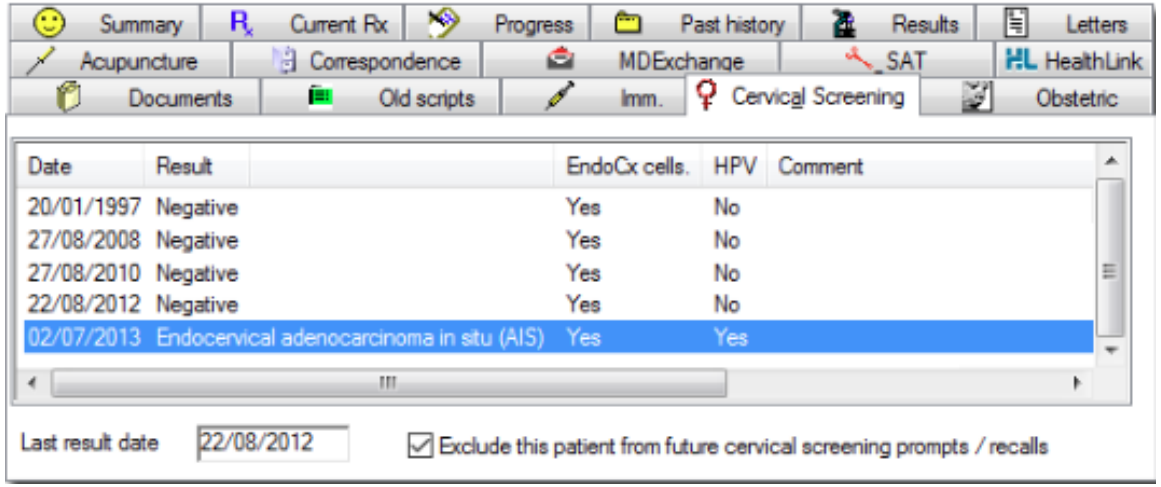
4. Indicate the patient's smoking and diabetes status, and ECG LVH. Note that this is not the same as 'echo LVH' which is a lesser risk factor.

5. Click **Save** button. A new entry appears within the recorded data on the right-hand side of this window. Note that this data is saved to this window for future reference, and a record is made in the patient's Progress Notes.



Recording Cervical Screening via the Patient's Record

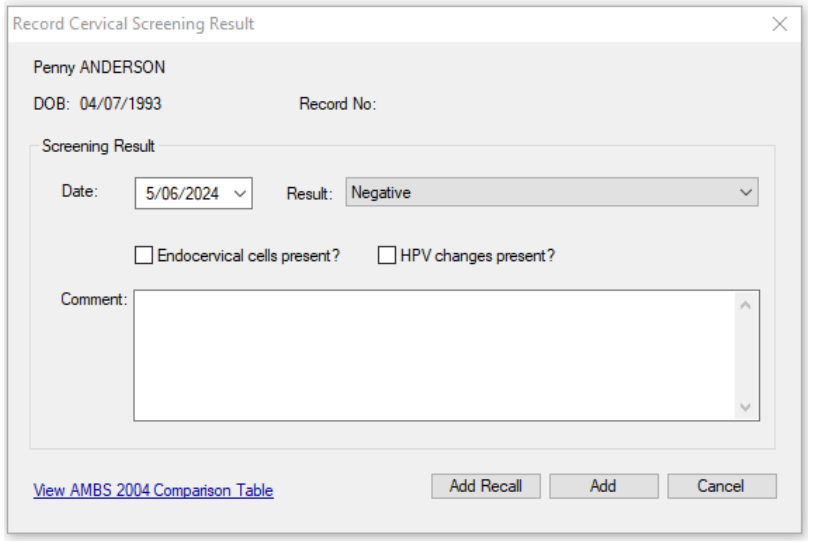
1. Select the Cervical Screening tab in the patient's clinical record.



2. Either,

- o Click
- o Press **F3**
- o 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.



- o Enter the date on which the screen was obtained from the patient.
- o Select a result type from the list provided.
- o Tick check boxes as appropriate to indicate whether Endocervical cells and/or H.P.V. changes were present.
- o 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.

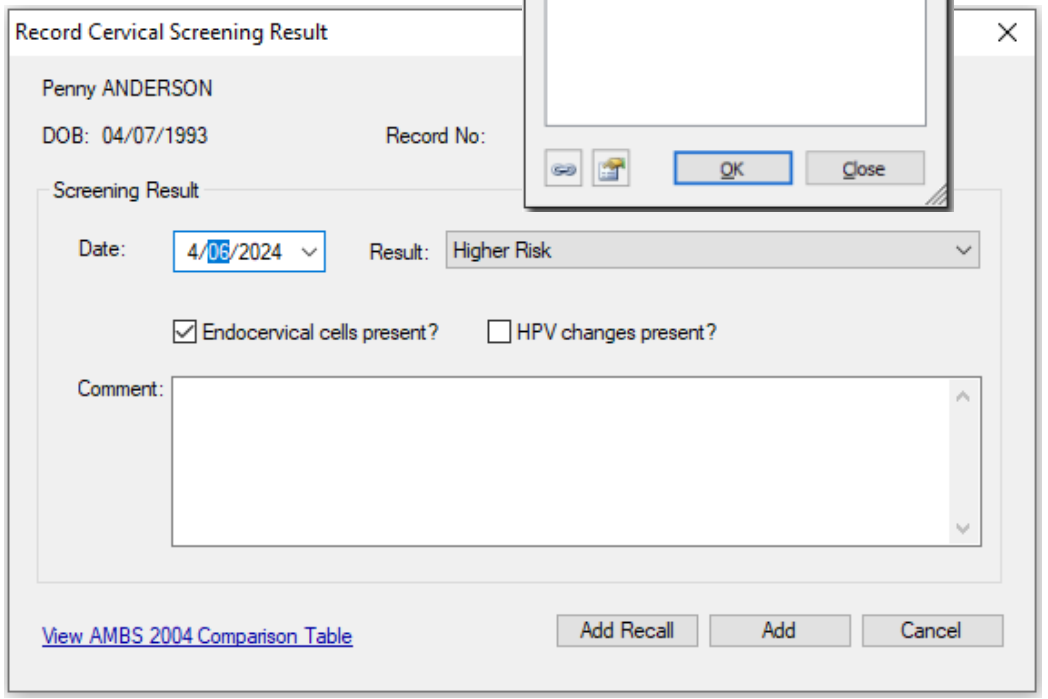
3. Once within the Holding File, locate and select the patient for whom you wish to manually record a cervical screening.

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

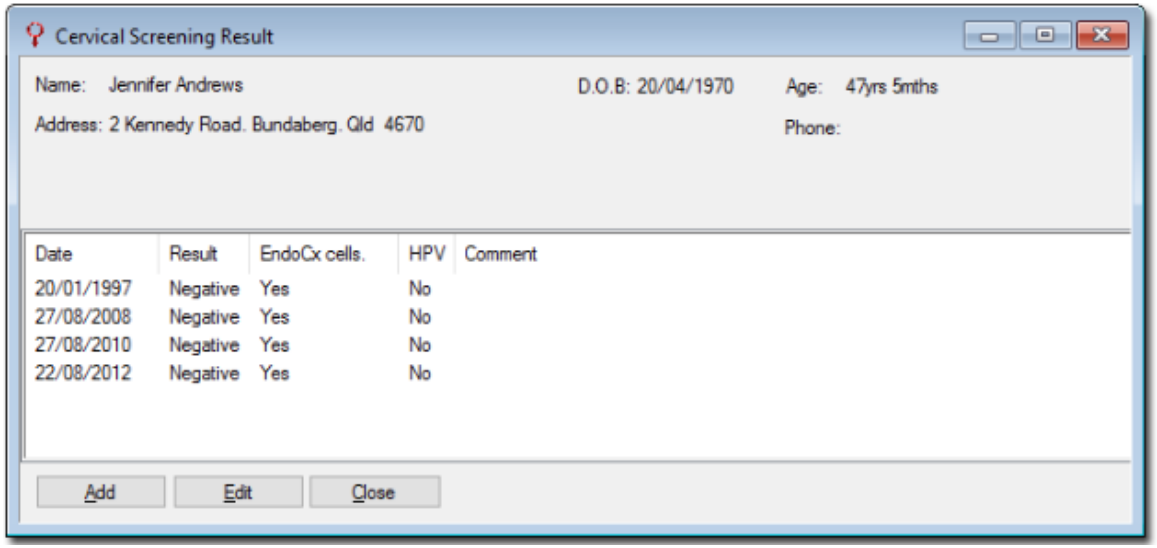
1. From the Clinical Front Screen, select **Clinical > Cervical Screen Results > Add Result**. The **Select Patient from List** window appears.

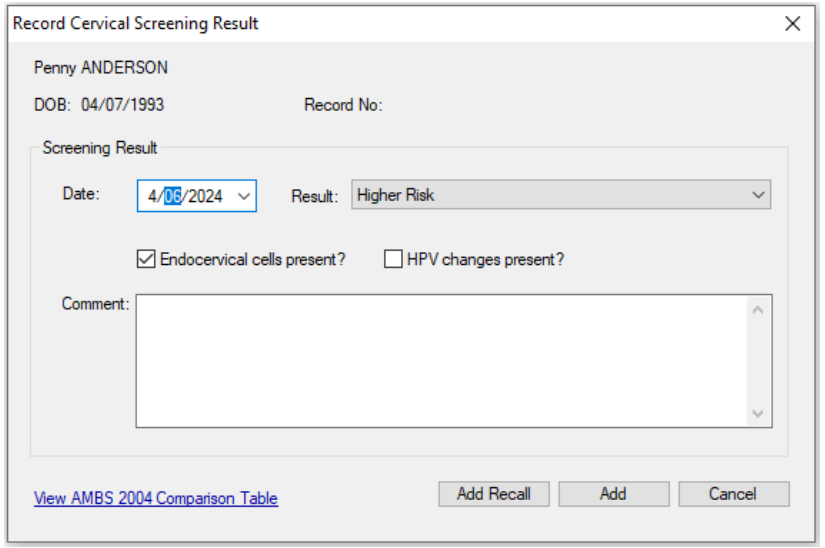
2. Search for and open the patient record you want to add a result for. The Cervical Screening Result summary for the patient will appear.

   - 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

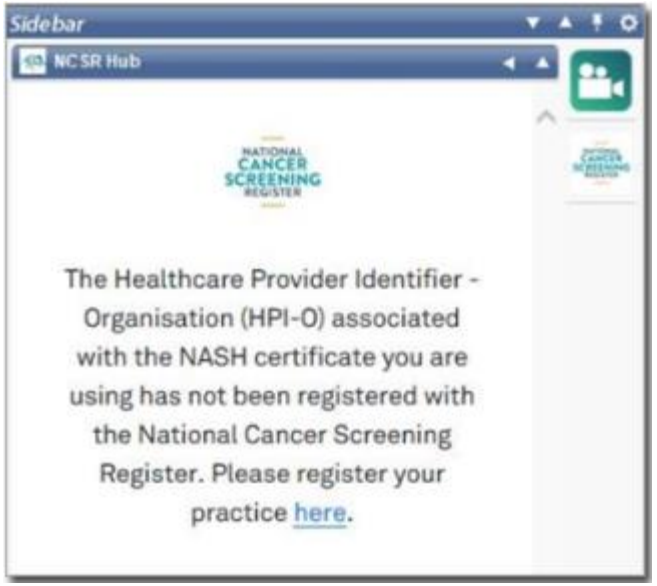
The National Cancer Screening Register enables a single electronic record for each person in Australia participating in cervical and bowel screening. The National Cancer Screening Register plays a vital role in supporting the National Cervical Screening Program (NCSP) and the National Bowel Cancer Screening 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:

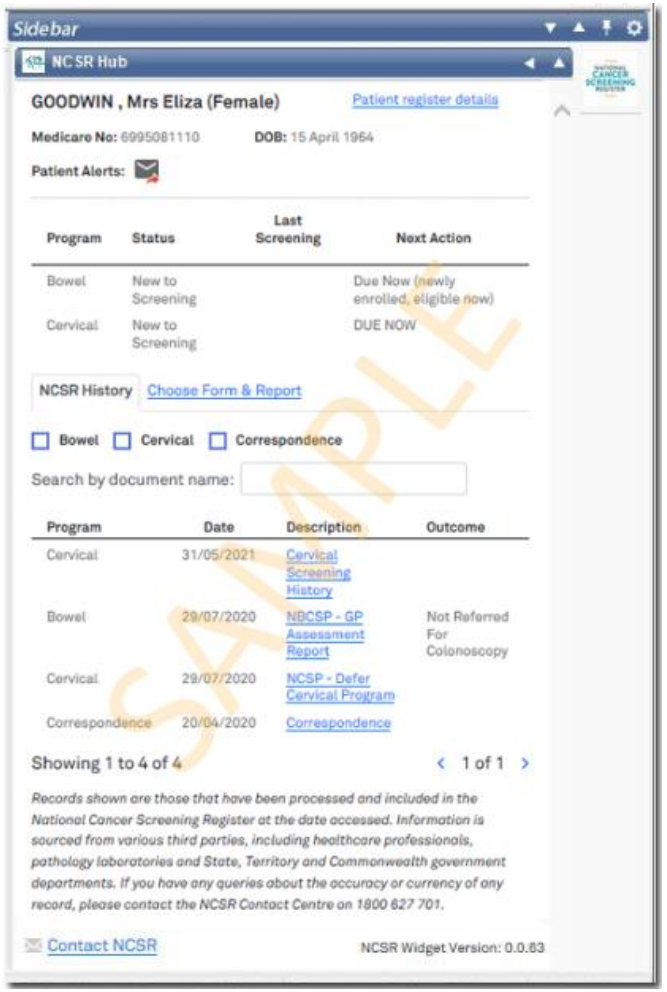
•Open the patient's record and view their test results, summary of the outcome and screening histories;
•View the patient's screening status and alerts;
•View the patient's next screening eligible date;
•Generate cervical screening history report;
•Submit Program forms to the Register – cervical and 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.

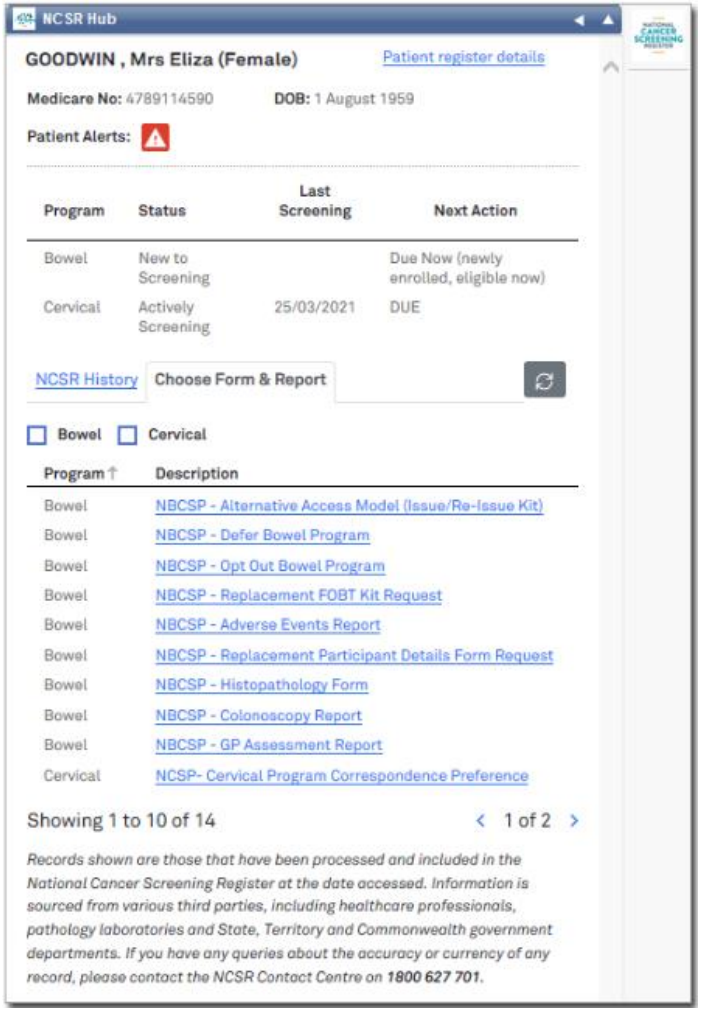


National Cancer Screening Register – Bowel & Cervical Screening

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.

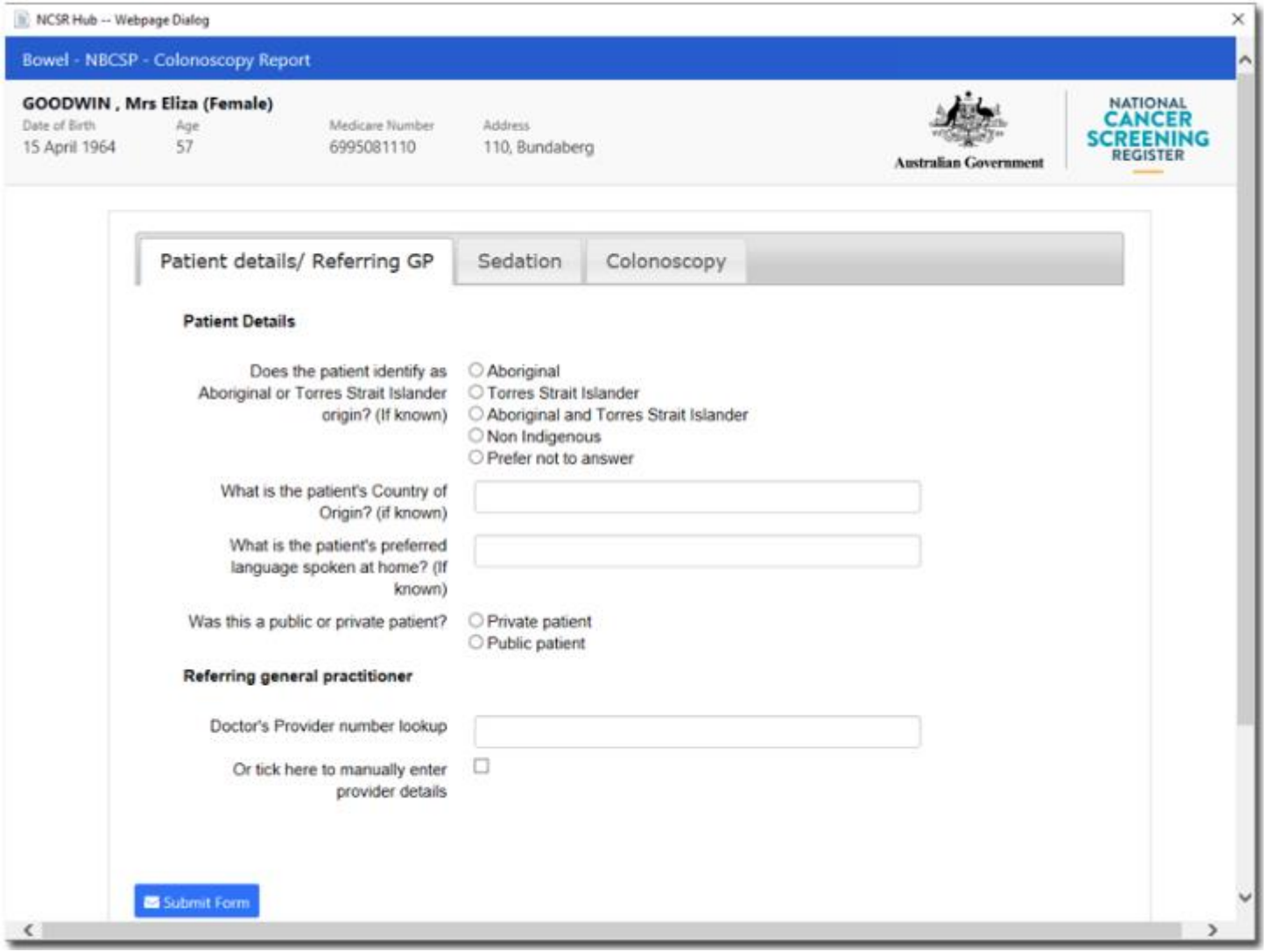


2. Switch to the **Choose Form & Report** tab to select a form/report to submit.



National Cancer Screening Register – Bowel & Cervical Screening

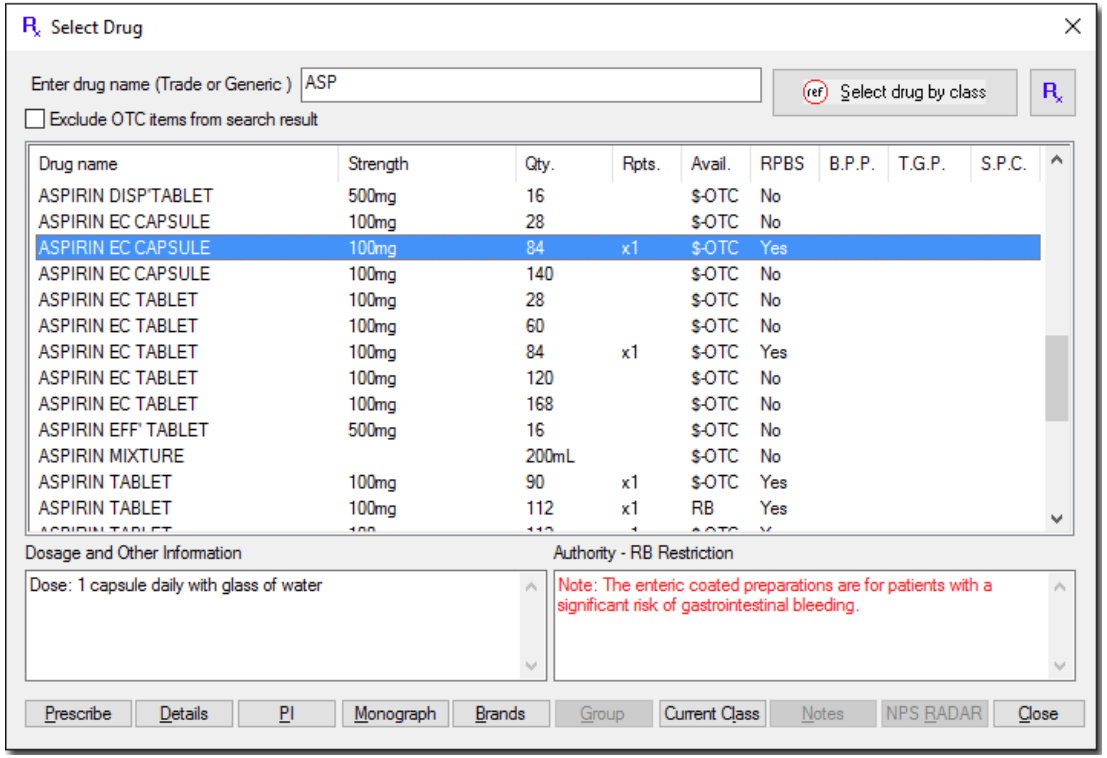
3. Complete and submit the form.



Prescribing Select Drug

There are a number of ways you can prescribe medications, all of which can only be performed from within a patient's Clinical Window:

•Select the Current Rx tab and then to add a new item, click or press F3 or ✚ right-click within the current medications list and select New Item from the menu. The Select Drug window appears. Proceed to Step 1 below, or
•To back-date a script, select the Current Rx tab and then to add a new item, enter the 'Script Date' as required at the bottom of the Current Rx tab, click ✚ or press F3 or right-click within the current medications list and select New Item from the menu. The Select Drug window appears. Proceed to Step 1 below, or
•Prescribe from your Drug Favourites list (should you have any favourites saved), by clicking ℞ in the toolbar. The Select Drug window appears. Proceed to Step 1 below, or
•Select a medication from within MDref. Within in MDref, highlight the item you wish to prescribe and then click **Prescribe** button at the bottom-left of the MDref Explorer window. The Enter Dose window appears. Proceed to Step 2 below, or
•Select from any Drug Protocols you have created. Proceed to Step 12 below, or
•Re-prescribe from the patient's old scripts. Select the Old Scripts tab, located and right-click the item you wish to re-prescribe, and select Prescribe Item from the menu that appears. Proceed to Step 2 below.



1. The Select Drug window appears.
Select an item by either:

o Typing the name of the medication into the Enter Drug Name text box (you need only type the first few letters for a search to commence), and double-clicking the drug or selecting the drug and clicking **Prescribe** button

Prescribing Selecting Drug by Class

2. (Optional) You can further filter the list of medications by:

o Ticking the Exclude OTC... check box to refresh the medications list to hide Over-The-Counter medications,

o Clicking **Brands** Button to show generically equivalent brand names with the same strength as the highlighted item,

o Clicking **Group** button to display all members of the Therapeutic Group to which the selected medication belongs. This button is only available to medications that belong to a Therapeutic Group,

o Clicking **Current Class** button to display all items from MDref that are in the same therapeutic class as the highlighted item.

o Right-clicking a medication, and selecting the 'Single and Multi-Ingredient Products' option, which allows you to see other medications that contain at least one of the same ingredients of the selected medication. See Single and Multi-Ingredient Products for more information.

3. Click **Prescribe** button to prescribe your medication of choice.

4. (Optional) Once you have selected the medication, you may be notified of any possible drug interactions.

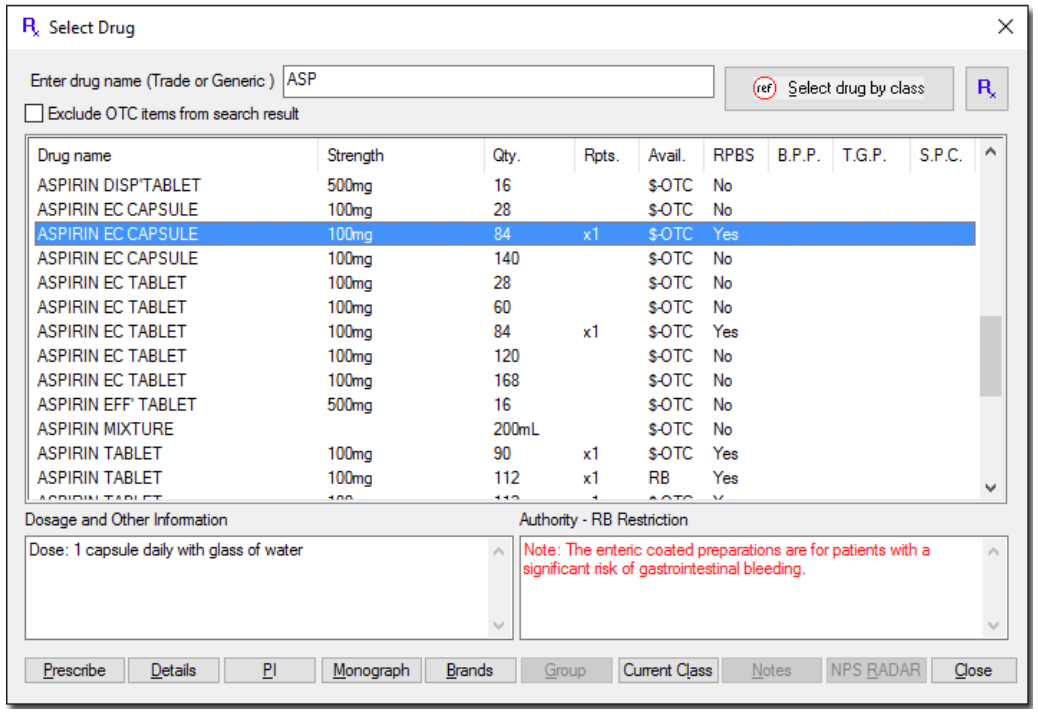
5. (Optional) If you have an existing Limited Prescription for this patient, a prompt is displayed. Select the most suitable option for your patient to continue.

o Accessing the MDref Class Browser by clicking **Select drug by class** button and selecting a drug from there

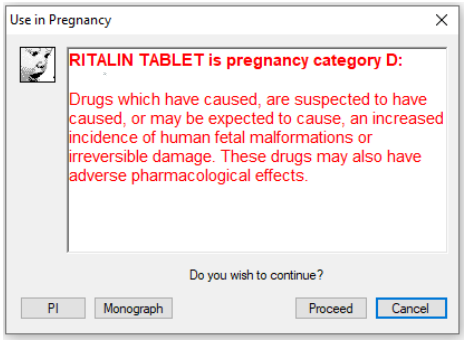
o Displaying your favourites list by clicking

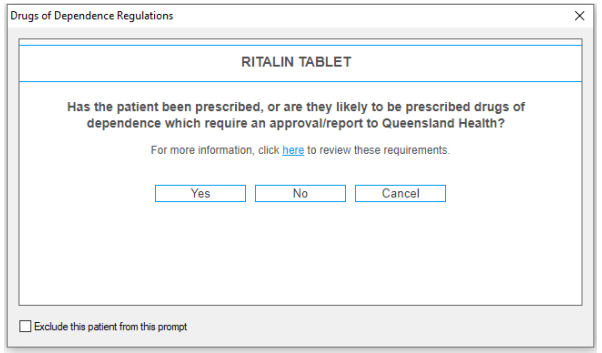
on the Select Drug window, and selecting a drug from the list that appears

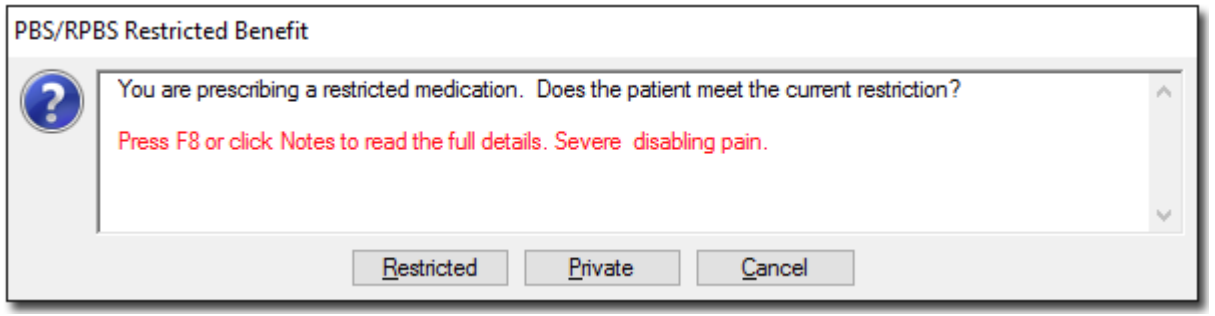
- PBS - Pharmaceutical Benefits Scheme
- RPBS - Restricted Pharmaceutical Benefits Scheme
- B.P.P. - Brand Price Premium
- T.G.P. - Therapeutic Group Premium
- S.P.C. - Special Patient Contribution



Drug Notifications





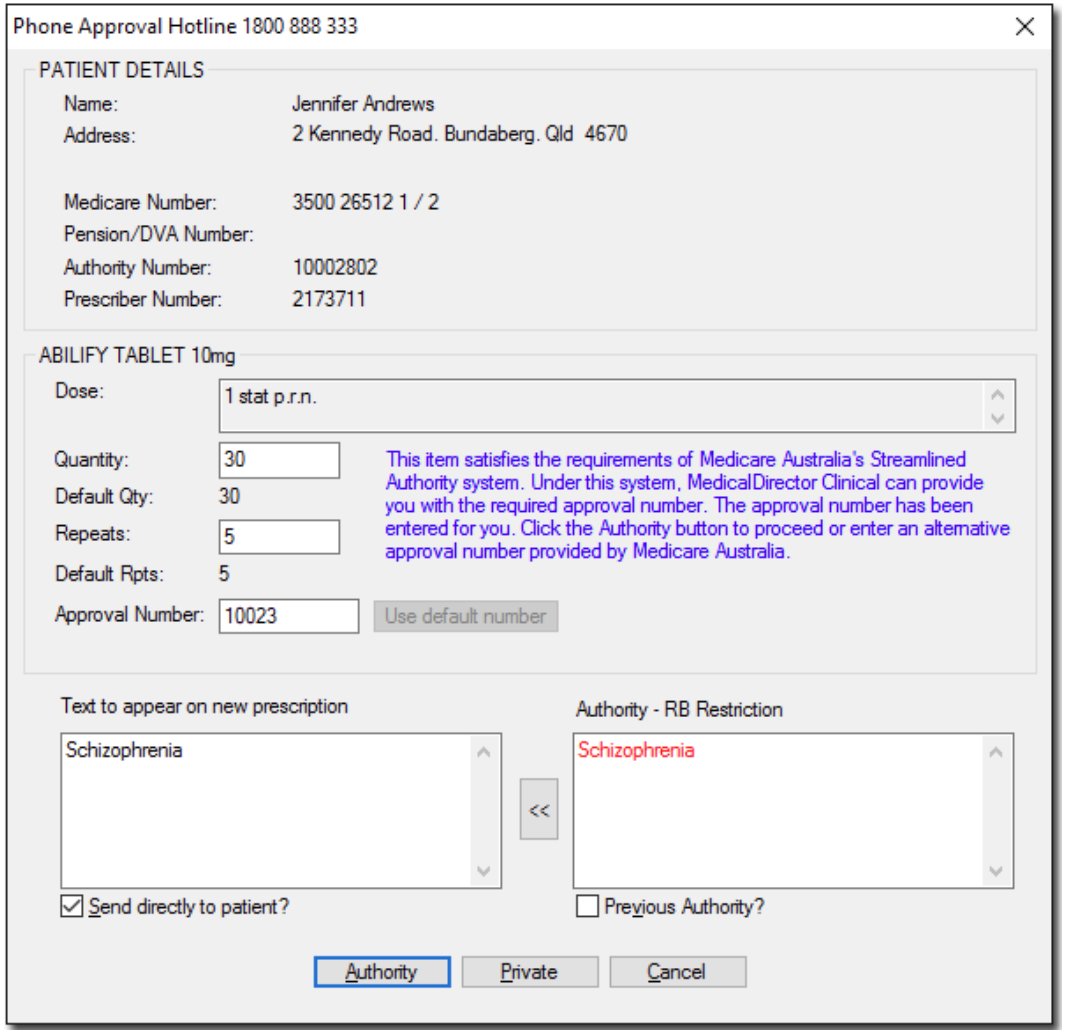


PBS/RPBS Codes	
PBS	Pharmaceutical Benefits Scheme unrestricted benefit
RB	Pharmaceutical Benefits Scheme restricted benefit
AUTH	Pharmaceutical Benefits Scheme Authority required
sAUTH	Pharmaceutical Benefits Scheme Streamlined Authority required
Sect. 100	Pharmaceutical Benefits Scheme Section 100 item
RPBS RB	Repatriation Pharmaceutical Benefits Scheme restricted benefit
RPBS AUTH	Repatriation Pharmaceutical Benefits Scheme Authority required
$-Rx	Private prescription
$-OTC	Product available without prescription
$-HOSP	Available only through hospital pharmacies
Medicare	Item payable as a Medicare benefit
SAS	Special Access Scheme item
Unregis'd	Product not registered with TGA

Authority Items

If a prescribed medication item requires an Authority, during the prescribing process an additional step is required; after the 'Dose/Frequency/Instructions' window has been completed, another window displays all the information that is required to obtain an Approval Number (by telephone).

- The Authority Number displayed is the 'Script Number', which must be quoted if you are required to (or choose to) obtain telephone approval.
- The Approval Number can be entered manually into the Approval Number text box if you are required to telephone for an approved number. Alternatively, using Medicare Australia's Streamlined Authority system, an Approval Number may be generated automatically for eligible medications. You can always change this number if you need to use a different Approval Number. Once changed manually, clicking **Use Default Number** button will reset the Approval Number to the default as dictated by Medicare Australia's Streamlined Authority system.
- If an Approval Number is entered, it is printed on the prescription. If it is not entered immediately, and telephone approval is subsequently obtained, it can be hand-written on the prescription in the appropriate places after the prescription has been printed.
- Some medications deemed eligible for Medicare Australia's Streamlined Authority system have multiple Approval Numbers associated with them that you can choose from. When these medications are prescribed, a **View List** button appears (in place of **Use default number** button shown in the image. On clicking **View List** button you will be presented with the Available Approvals window from which you can select an appropriate Approval Number.
- The quantity and number of repeats can be altered if necessary. For medications deemed eligible for Medicare Australia's Streamlined Authority system you can decrease the quantity and repeats without affecting the pre-generated Approval Number. Increasing these figures will require that you obtain an Approval Number.
- Check boxes are provided on this window to allow the Authority to be marked to indicate if a previous Authority has been obtained, and whether the prescription is to be sent to the patient or returned to the practitioner.
- Buttons allow you to choose whether the item is to be printed as an Authority prescription or as a Private prescription. If Private is chosen, the drug's code is changed from 'A' to '$', and it is printed on a private prescription.
- If **Authority** button is clicked, the item is printed as an Authority prescription. The text appearing in the edit box is printed on the Medicare Australia copy of the prescription as the Indication for Authority. This text can be edited if required. For example, some drugs require the date of an endoscopy to be added to the indication. In other cases, the same item may have multiple approved indications. The text should be edited so that the appropriate indication is displayed. When **Authority** button is clicked, the edited text is stored in that patient's record so that when subsequent Authority prescriptions are written, the text does not need to be re-edited.
- When the Authority prescription is printed, the third (Medicare Australia/DVA copy) and fourth (Practitioner's copy) copies of the prescription are printed on the white space below the original and duplicate. As MedicalDirector Clinical also keeps a copy of the prescription, it is not necessary for the prescriber to keep the printed fourth copy, however Medicare Australia requires it to be printed.
- Because of space limitations, it is not possible to put lengthy instructions on authority prescriptions, and they are truncated to fit into the available space.



AusDI by Telstra Health

AusDI content is accessed daily by

17,500+ GPs across 4,500+ practices in their MedicalDirector Clinical and Helix prescribing software

11,000+ dentists and 350+ nursing homes

Universities, public and private hospitals across Australia

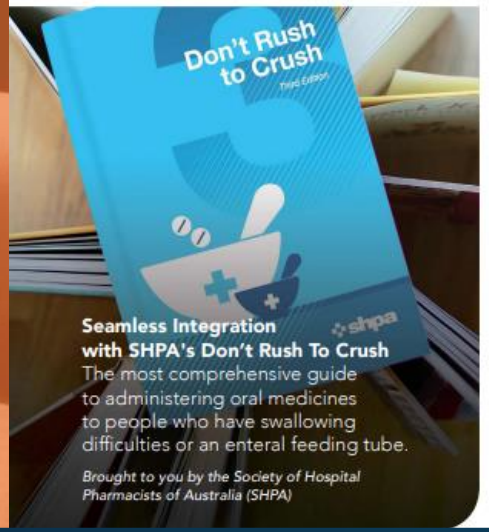
Retail pharmacists and accredited pharmacists engaging in medication reviews

Australia's most up-to-date medicines database

Supports industry compliance

Pharmacy Board of Australia and Pharmacy Registration Board of WA
AusDI helps to support compliance requirements featured in the list of essential reference texts for Pharmacists.

Pharmaceutical Benefits Scheme (PBS)
AusDI is updated daily by an Australian based pharmacy editorial team under the guidance of an independent editorial advisory committee. It is then published monthly in accordance with the latest PBS Schedule.



Dispense and prescribe with confidence

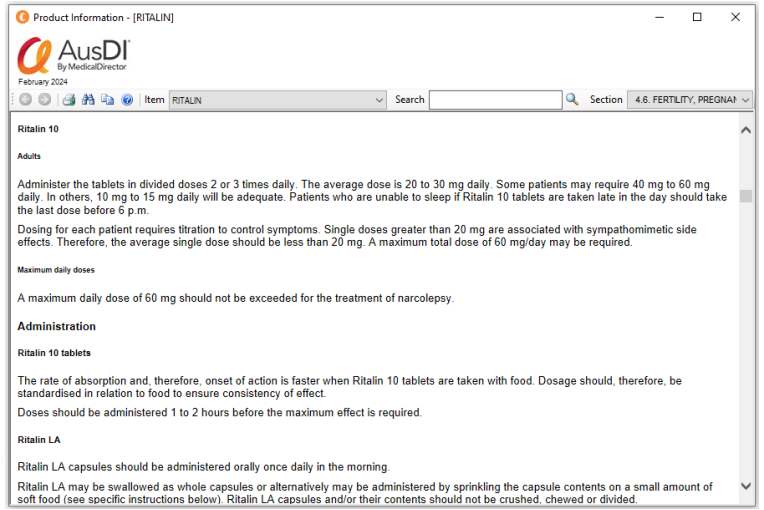
Independent drug monographs
Obtain a suite of independently authored, clinically relevant monographs written at a single drug or class level covering both Therapeutic Goods Administration (TGA) approved and off-label indications, pharmacology/pharmacokinetics, precautions, side/adverse effects, counselling points and dosing information.

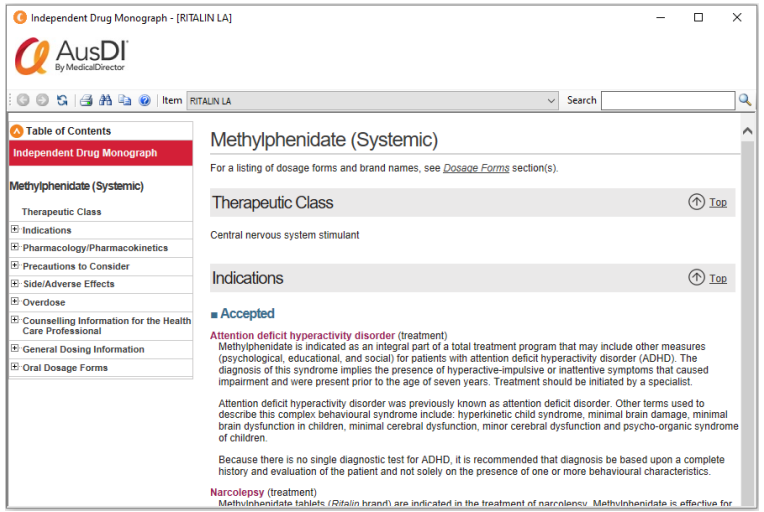
Product identifier
Identify unknown products based on physical characteristics such as shape, scoring, colour or markings.

Product information
Access the most recent TGA approved content sourced directly from multiple sources.

Consumer medicines information
Find the most recent documents sourced directly from pharmaceutical manufacturers in pdf format.

Drug interactions and safety
Identify clinically significant drug-drug, drug-food and drug-complementary medicine interactions, duplicate therapy warnings and shared adverse effects.





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Prescribing Product Information, Prescribing options & more

6. The Enter Dose window appears. It is within this window that you record data about the dosage of the medication you are prescribing. You can also access Product Information about the medication via **PI** button.

7. Set the dosage (using the Dose Calculator if desired).

8. Select a frequency.

9. Indicate instructions as required, from either the list provided or by using stored text from the MedicalDirector Clinical Glossary.

10. Choose a Route of Administration from the list provided.

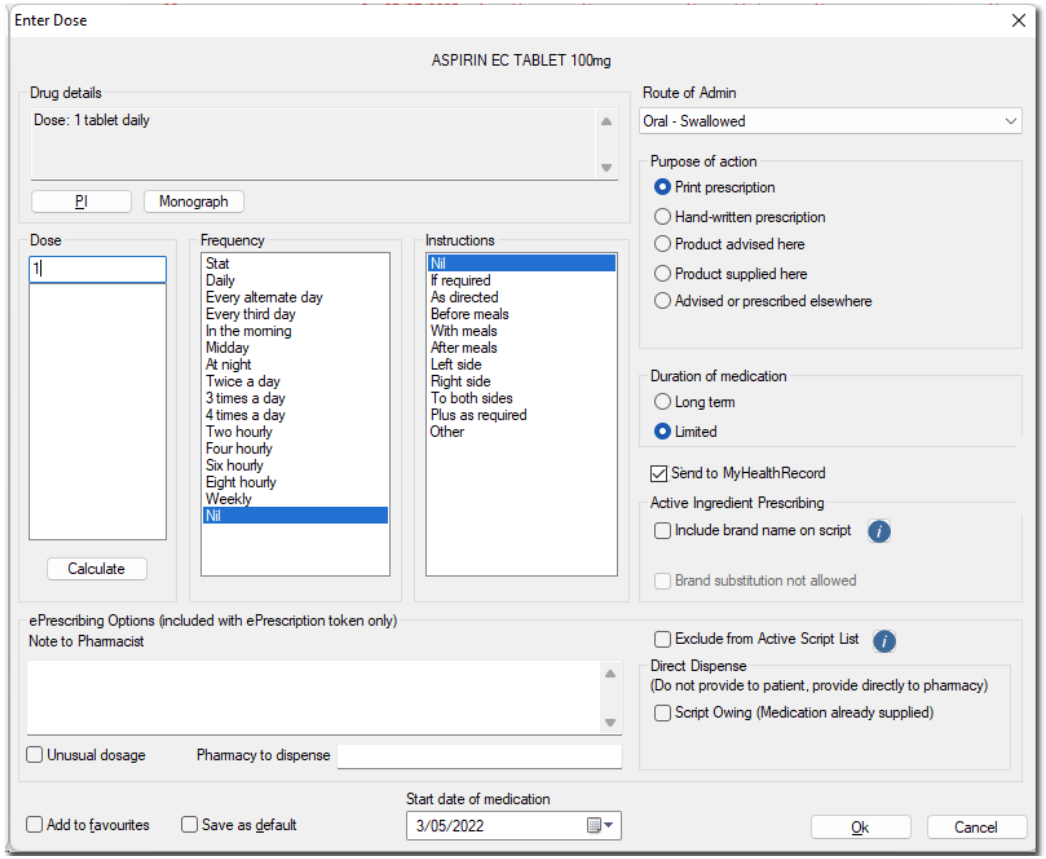
11. Select one of the Purpose of Action options, including:

- Product Advised here. Allows you to recommend a medication that does not require a script to be printed, such as cough syrup.
- Product Supplied here. Allows you to administer a medication without printing a script. For example, you may wish to administer a medication that you stock at your practice.

12. Select the Duration of Medication; Long Term or Limited. The default is Limited, which can be altered via Prescribing Options.

13. Long Term. Allows you to prescribe an on-going medication. When the medication runs out it is assumed it will be renewed (e.g. insulin injections for diabetes). Long Term medications remain on the Current Rx tab until manually deleted.

14. Limited. Allows you to issue the prescription for once-off or limited duration medication (e.g. cough medicine). Limited medications remain on the Current Rx tab even when the estimated duration expires, at which time a prompt will notify you of the cessation upon opening the patient's record.



Prescribing Active ingredient, Brand, Favourites & more

15. (Optional) Tick the MyHealthRecord Consent check box to indicate that you have the patient's consent to add details of this prescribed medication to the patient's My Health Record record. An indication of the patient's consent is displayed under the MyHealthRecord Consent column on the Current Rx tab.

    This check box is only available if the following conditions have been met;

- You have enabled My Health Record
- You have enabled ePrescribing

This check box is ticked by default, unless the patient has set their record privacy to 'non-advertised' via the My Health Record consumer portal (a check for this setting is made upon opening the patient's record in MedicalDirector Clinical). If during the consultation the patient changes their mind, and grants consent to upload a given medication to their My Health Record, you can tick this check box now. Under such circumstances, patient consent must be granted per medication i.e. this check box will be un-ticked for subsequent medications until such a time as the patient logs onto the consumer portal and changes their record privacy.

Scripts approved for uploading to the My Health Record System in this manner are transferred when you print the script.

16. (Optional) Tick the Include Brand Name on Script check box if you wish to print the medication's associate brand name on the script. See Active Ingredient Prescribing for more information.

17. (Optional) Tick the Brand Substitution Not Allowed check box if required.

18. (Optional) Tick the Exclude from Active Script check box

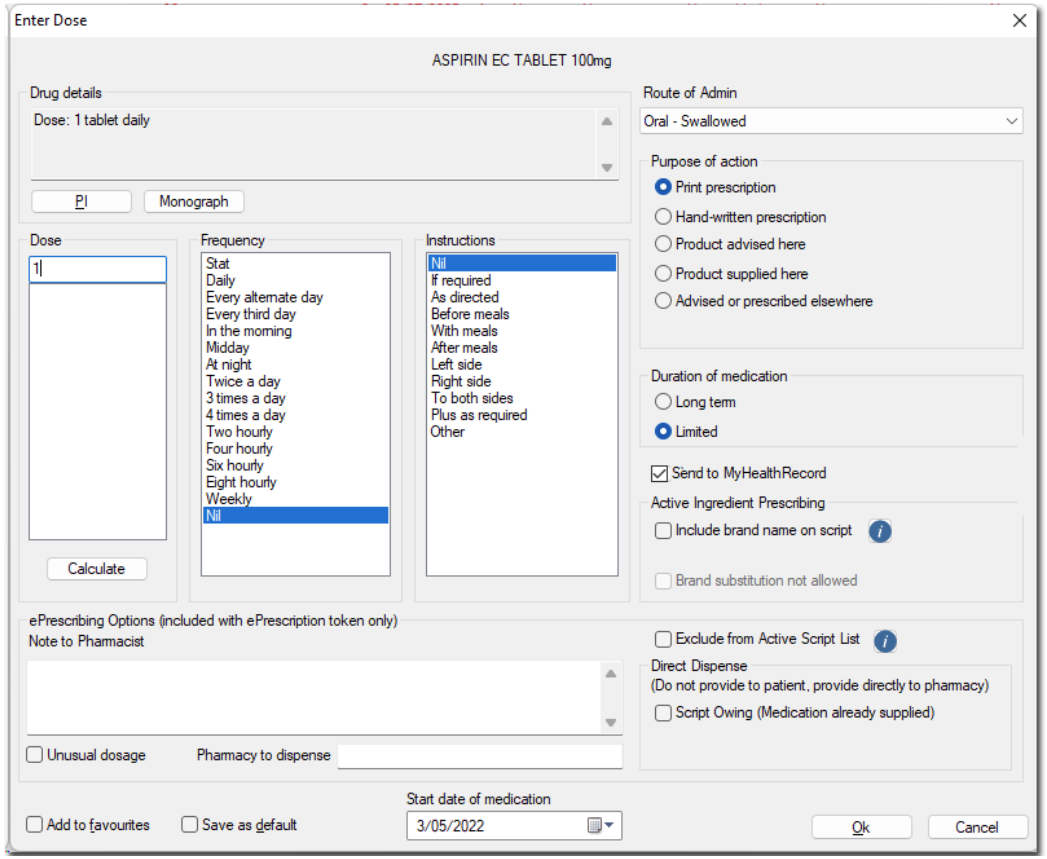
19. (Optional) Tick the Script Owing check box to print a QR code to fax/email the pharmacy directly, instead of handing to the patient.

20. (Optional) Tick the Add to Favourites check box to add the drug to a favourites list, which is accessible when prescribing via

21. (Optional) Ticking the Save as Default check box saves the dosage, instructions and duration so they are available next time the drug is selected.

22. Record the start date of the medication. The default date is the current date.

23. Click **OK** button when you are ready to continue.

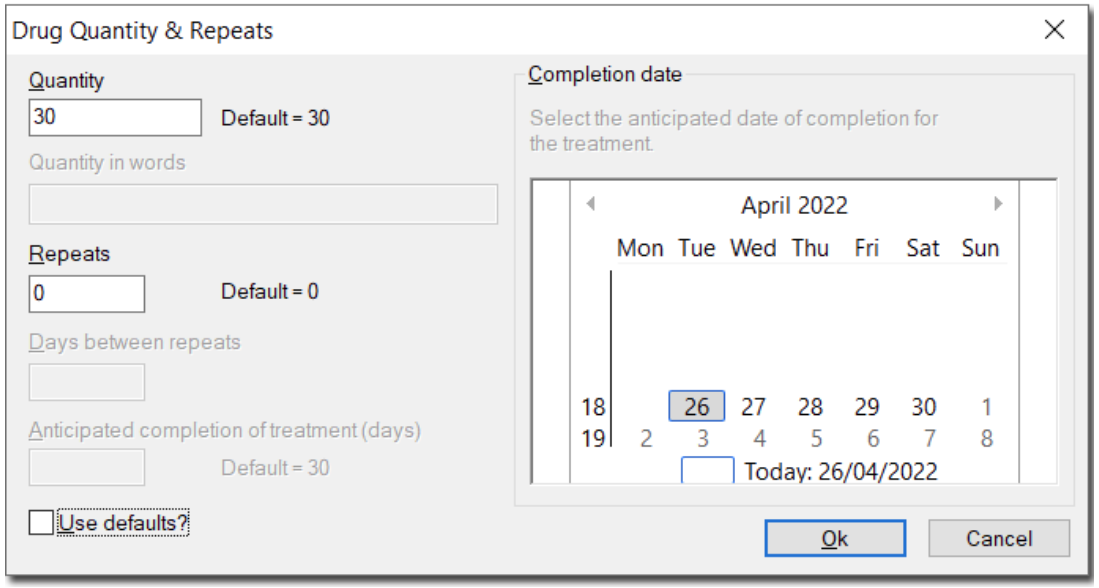


Prescribing Drug Quantity & Repeats

25. You will be prompted to confirm the drug quantity and repeats. Modify if necessary and click **OK** button to continue.

    This prompt will differ slightly, depending on whether you are prescribing a limited or regular medication. It is possible to disable the prompt for regular medications via Prescribing Options.

26. (Optional) If you are prescribing a PBS/RPBS Restricted Benefit medication, you will be prompted accordingly. See PBS/RPBS Restricted Benefit Medications for further information.



Prescribing

27. The Reason for Medication window appears, prompting you to record a reason for the medication. This is optional, so if you wish not to record a reason click Close. See also the Diagnosis Coder.

If you choose to enter a reason, either;

o Pick a hard-coded reason by typing the first few letters of the reason into the Pick from List (Coded) text box, and then selecting the reason from those that appear in the corresponding list, or

o Enter a custom reason by selecting the Free Text (Uncoded) option and then typing the reason into the corresponding text box, or

o Select an existing reason from the Existing Past Medical History Items list.

o The following options are also available from this window:

• Save in Past Medical History check box. Ticking this check box will save the Reason for Medication to the patient's Past History tab. Enabling this check box also makes available the Active, Confidential and Summary check boxes.

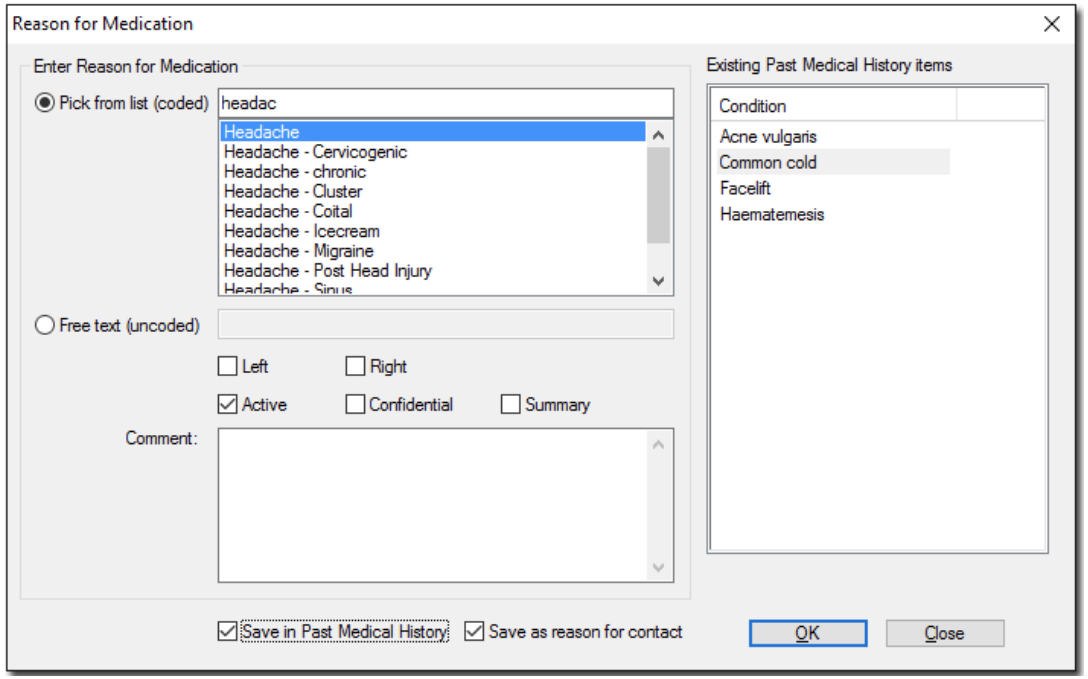
• Save as Reason for Contact check box. Ticking the Save as Reason for Contact check box will add a corresponding note to the patient's Progress Notes.

• Left and Right check boxes. The Left and Right check boxes allow items to be marked as either on the left side of the body, right side of the body or by ticking both, bilateral.

• Active check box. Ticking this check box will save the Reason for Prescription to the patient's Past History tab and flag it as an active condition.

• Confidential check box. Ticking the Confidential check box prevents the item from being printed on letters, Pathology/Radiology requests, or in printed history summaries for the patient's chart. It is provided so that sensitive items (e.g. termination of pregnancy) will not appear on a referral for an eye examination, for example.

• Summary check box. The Summary check box allows items to be marked as summary items. They will appear on printed summaries and on letters/request forms (provided they have not been marked as Confidential). If not marked as a summary item, the item will appear on-screen, but will not appear on any printed output. This prevents the printed summaries, letters and request forms from becoming too lengthy with relatively trivial entriesi.e. only items of significant importance in the patient's Past History should be marked as Summary items.



28. Click OK button when you are ready to continue.

29. The Select Drug window reappears, awaiting further prescriptions (this functionality can be disabled via Prescribing Options).

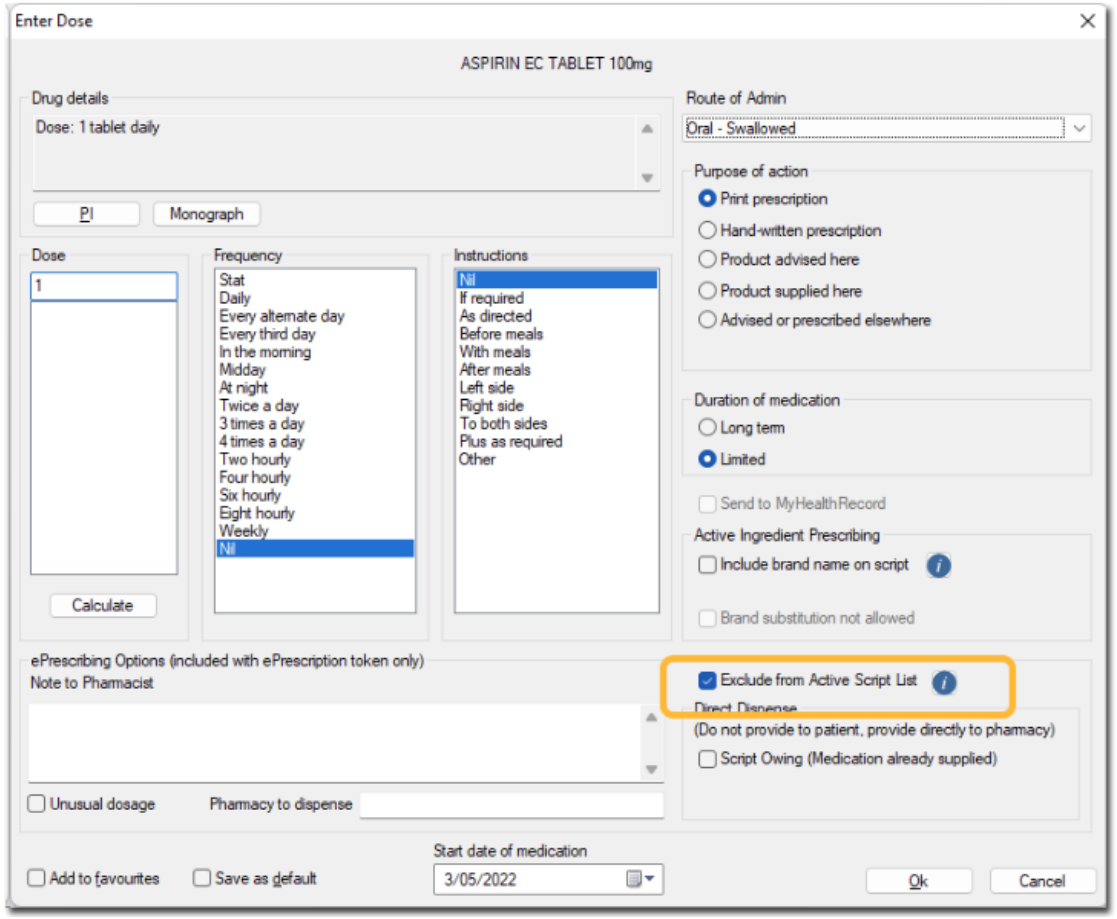
o Proceed with the prescribing of further items if you wish, or click Close to cease.

o Prescriptions that you have added now appear within the patient's Current Medications List (Current Rx tab), and are flagged as ready for printing.

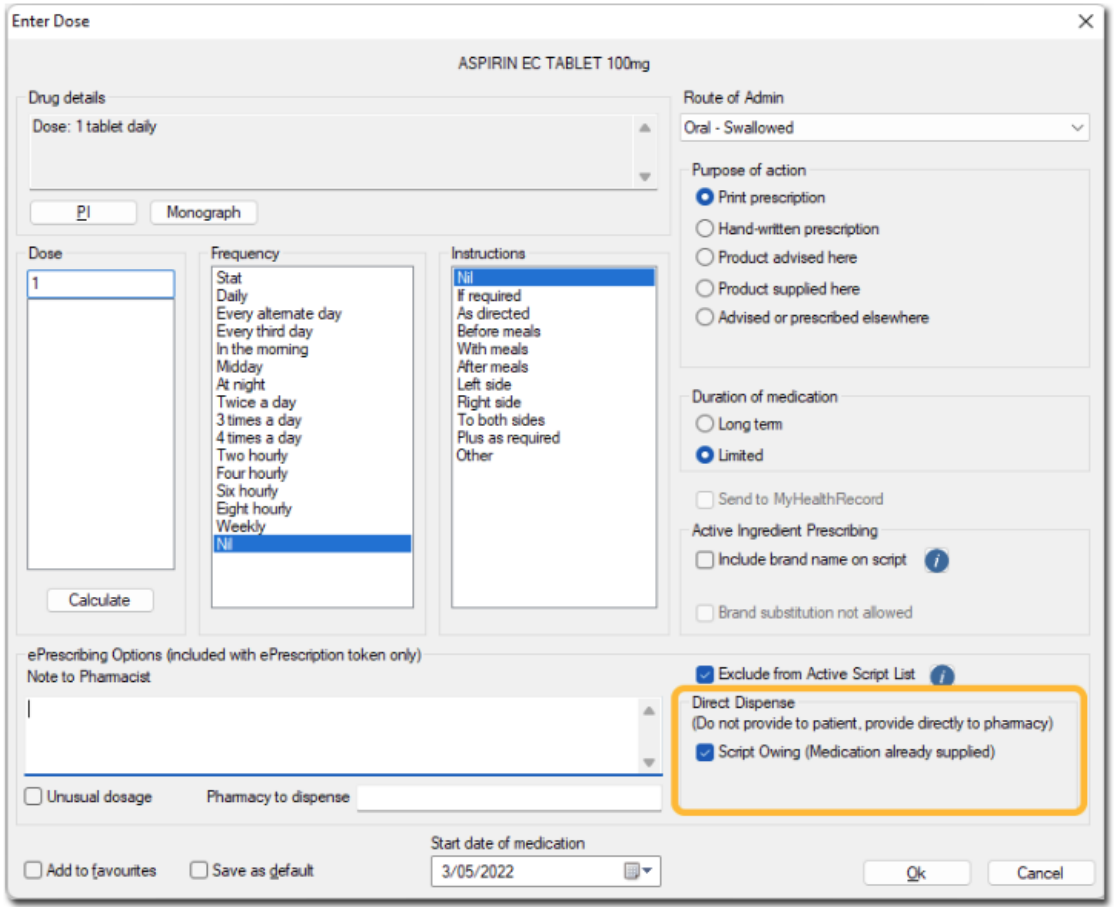
30. Print scripts as required.

Paperless Electronic Prescribing

You can indicate whether the patient wants the medication to appear on their active script list.

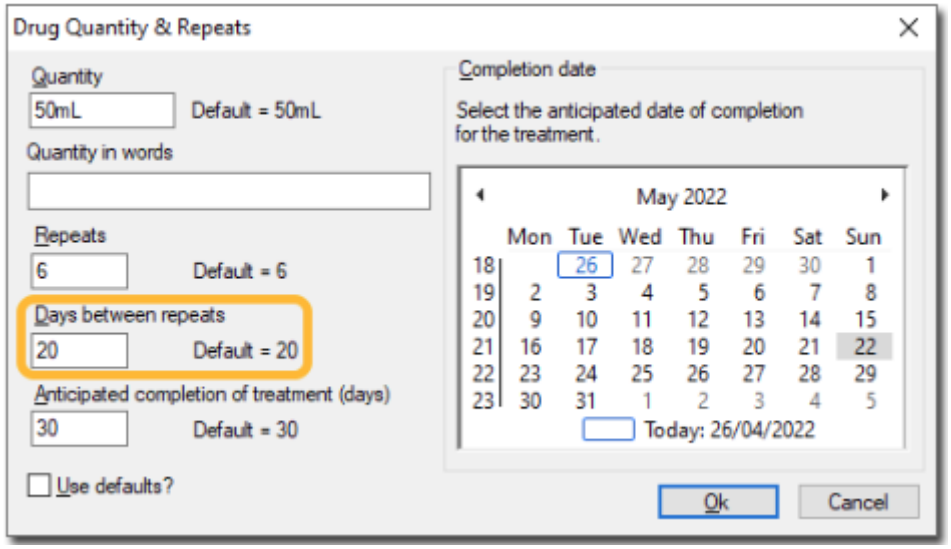


When an item is marked as 'Script Owing' on the Enter Dose window, only paper tokens will be permitted (no SMS or email).



Paperless Electronic Prescribing

When an item is a Schedule 8 (S8) medication, you will be prompted for an approval / authority / warrant / permit number.



- When an item is a Schedule 4B (NSW) or Schedule 4D (TAS) medication (e.g. TESTOSTERONE CREAM), altering the number of repeats activates the 'Days between repeats' field on the 'Drug Quantity & Repeats' window. This is existing behaviour for S8 items but was expanded to include the S4B and S4D.

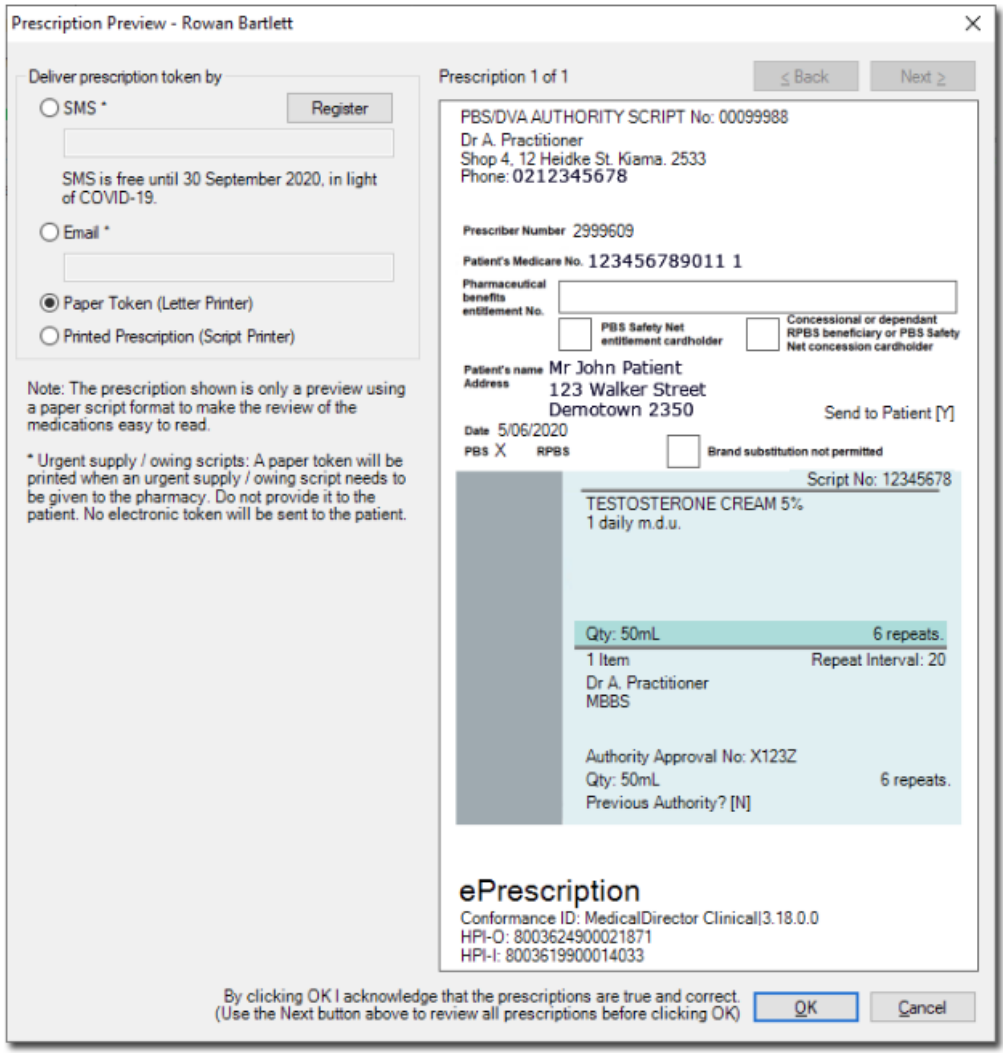
Paperless Electronic Prescribing

The Prescription Preview window additionally provides the options to SMS or Email an electronic token or print a paper token.

- A suggested delivery method will be preselected for you. This selection is determined by information found in the patient's record, with priority going to SMS followed by Email and then Printed media.

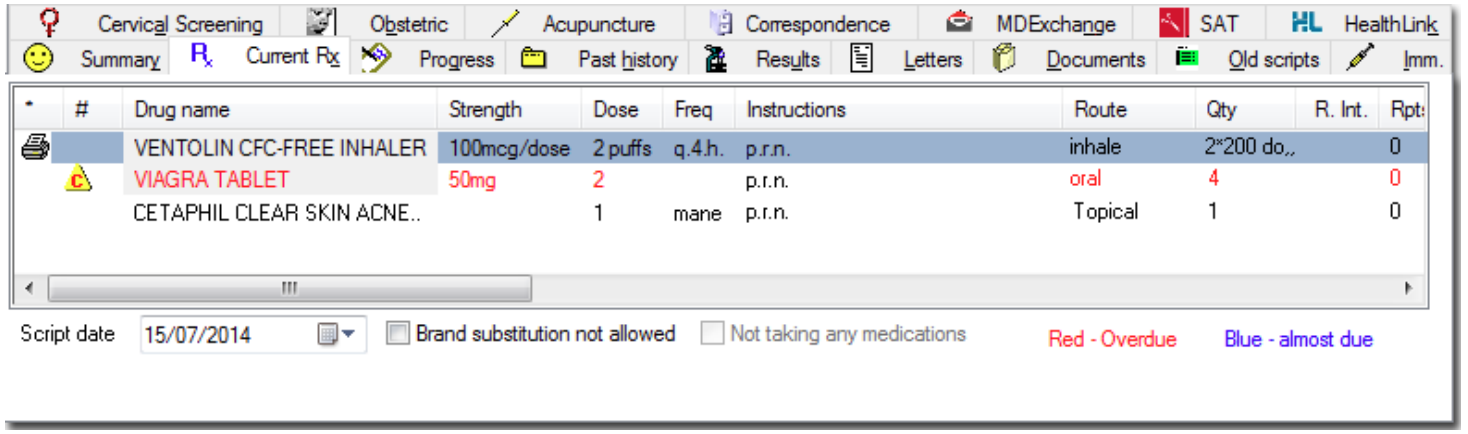
If the user has specified a Prescriber Type other than 'Medical Practitioner' or 'Nurse', and their state is either ACT or SA, 'Restricted Use For' information appears on prescriptions.

SMS fees are subsidised until 31 July, 2027.
Please enable SMS via Settings > Centre, before government subsidies expire, to continue to provide patients with SMS prescription delivery.



Keeping Medications Current

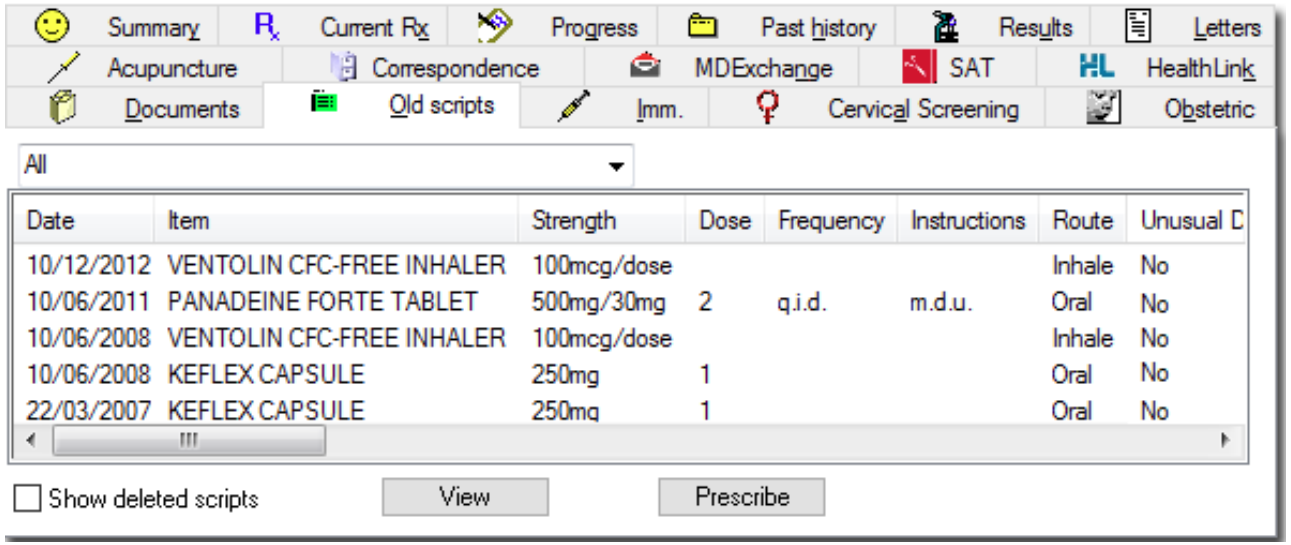
Once Real Time Prescription Monitoring is enabled, the practitioner will be prompted with the Real Time Prescription Monitoring warning when S8 drugs and other high risk medicines such as benzodiazepines, zolpidem or zopiclone, quetiapine and codeine are prescribed.



Real Time Prescription Monitoring Notifications

The practitioner will get a Real Time Prescription Monitoring prompt after performing the following on any S8 drugs and other high risk medicines such as benzodiazepines, zolpidem or zopiclone, quetiapine and codeine.

- When adding drugs to the Current Rx tab.
- When Changing 'Dose' in Current Rx tab
- When Changing 'Quantity' in Current Rx tab
- When Changing 'Strength' in Current Rx tab
- When re-prescribing a current high-risk medication via the patient's Old Scripts Tab



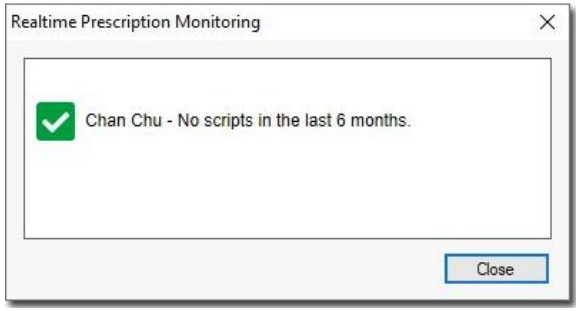
See Managing and Modifying Current Prescriptions

Keeping Medications Current

A **GREEN** notification will appear in the following situations:

- When there has not been a prescription issued/dispensed for a monitored medicine in the last 6 months or
- When prescriptions for a monitored medicine in the last 6 months have been issued by the same prescriber/medical practice, and there are no alerts

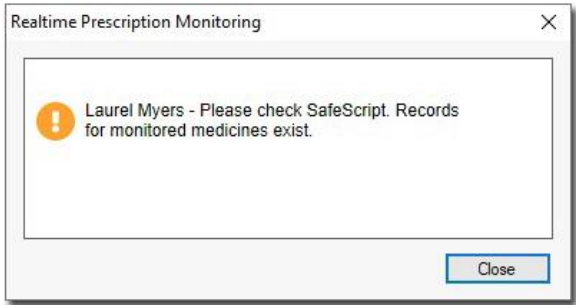
When use of Real Time Prescription Monitoring becomes mandatory, prescribers/pharmacists will not be required to click on the notification to review the patient history.



An **AMBER** notification will appear in the following situations:

- When prescriptions for a monitored medicine in the last 6 months have been issued by more than one prescriber/medical practice or
- When the daily morphine equivalent dose (calculated based on an average over the last 90 days) is between 50mg and 100mg MED daily (i.e. a medium risk dose)

When use of Real Time Prescription Monitoring becomes mandatory, prescribers/pharmacists will be required to click on the notification to review the patient history to assess whether it is safe or appropriate to prescribe/dispense a medicine.



A **RED** notification will appear in the following situations:

- Patient has active alerts within the last 3 month (90 days)

A RED notification will appear when there is a current alert relating to the prescribing/dispensing history of a patient.

These alerts are:

- Multiple provider episodes: When prescriptions from 4 or more prescribers/medical practices or 4 or more pharmacies have been recorded in Real Time Prescription Monitoring within the last 90 days.
- High-risk drug combinations: When prescriptions for certain drug combinations have been recorded in Real Time Prescription Monitoring within the last 90 days.
  - Methadone + a benzodiazepine
  - Methadone + a long-acting opioid
  - Fentanyl + a benzodiazepine
  - Fentanyl + a long-acting opioid
- Opioid dose threshold: When the daily morphine equivalent dose (calculated based on an average over the last 90 days) exceeds 100mg MED daily (i.e. a high risk dose).

When use of Real Time Prescription Monitoring becomes mandatory, prescribers/pharmacists will be required to click on the notification to review the patient history to assess whether it is safe or appropriate to prescribe/dispense a medicine.

Reviewing Results via Holding file

Holding File for All Patients

1. Select Correspondence > Check Holding File (All Patients).

2. You will be prompted to select one or more recipients whose results you wish to examine.

3. From this window select the recipient(s) whose results you wish to examine:

o Select a single recipient by clicking their name, and then clicking OK to open the Holding File to display only their results. Alternatively you can double-click a name to simultaneously select them and open the Holding File.

o Select multiple recipients by clicking each name. To deselect a name, simply click it again. Then, click OK to open the Holding File to display only the results of the selected recipients.

o Select all recipients by clicking the All Recipients option. Clicking OK then opens the Holding File to display results for all recipients. Alternatively you can double-click the All Recipients option to simultaneously select all recipients and open the Holding File.

Note that, as making a selection from this window locks the results associated with the selected recipient, it is recommended that you select only a specific recipient, as selecting All Recipients will prevent others from accessing any results whilst you have the Holding File open.

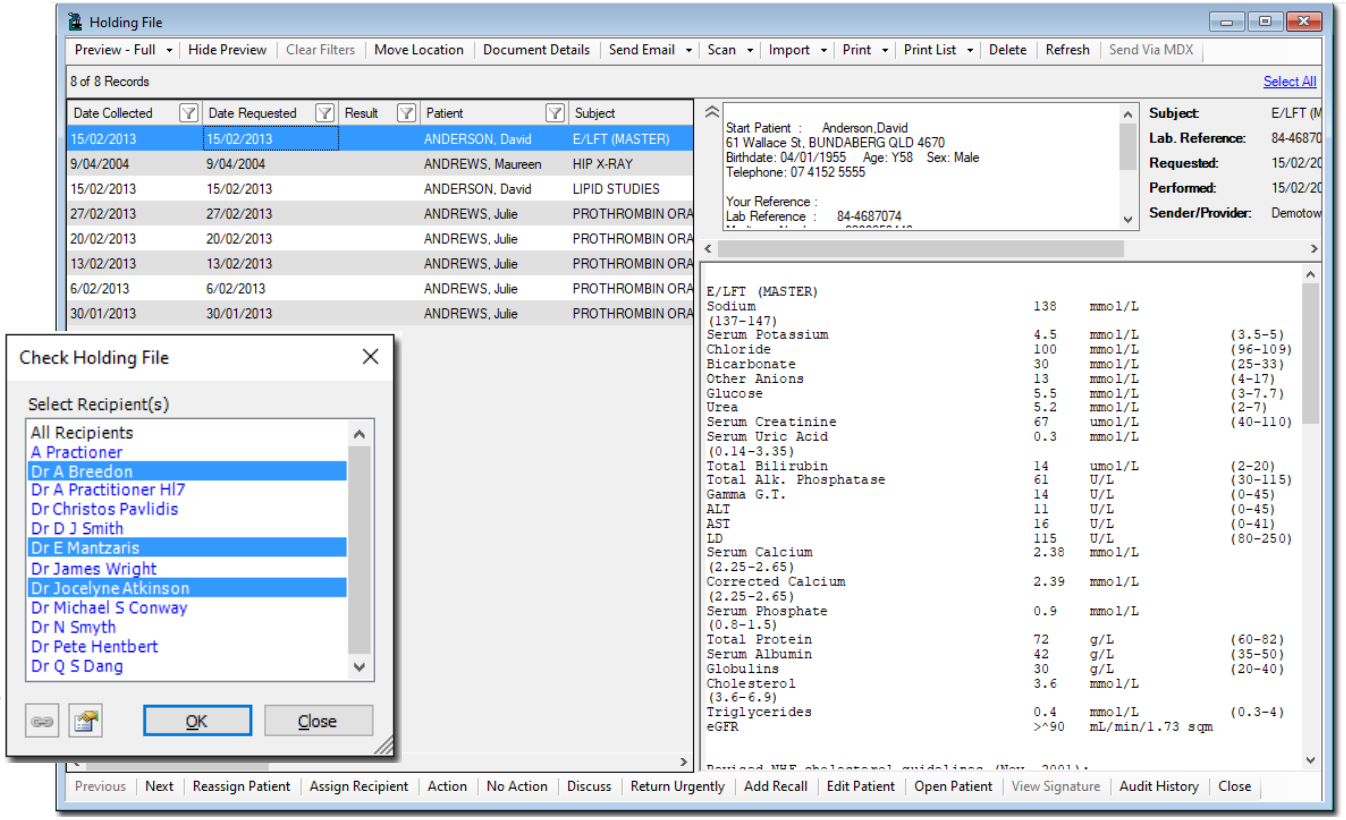
4. You will then be presented with the Holding File.

5. (Optional) Upon opening the Holding File, the first result in the list is automatically selected and displayed. If Clinical cannot determine which patient the result relates to, you will be prompted to either add a new patient to the database (by clicking Add New button, or select from a list of patients the result could possibly belong to, as seen in the following example.

6. Within the Holding File you can check-off Results. See Checking Off New Results for information.

7. Review the table below for information on using the Holding File.

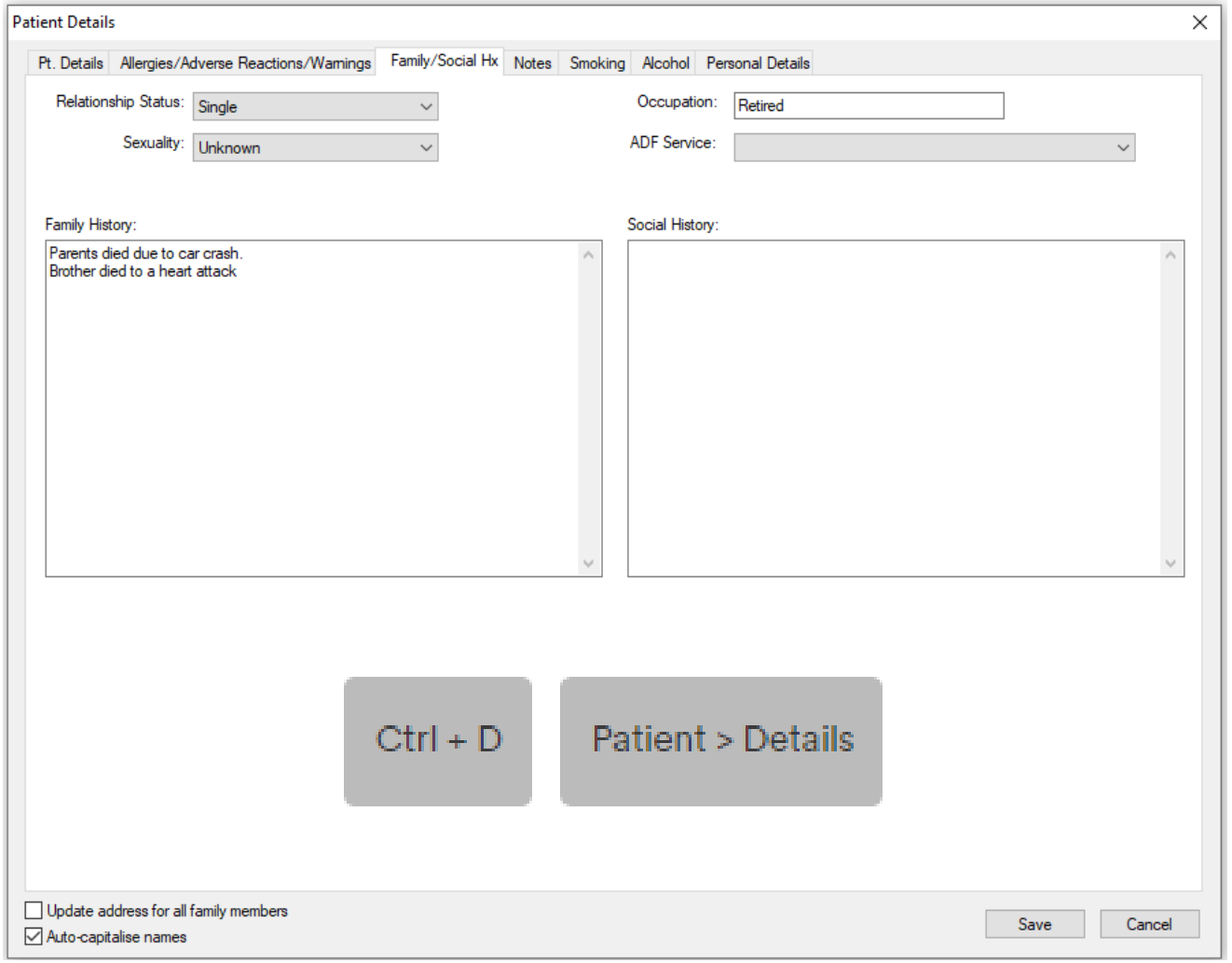
See Filtering/Searching Correspondence Records for more information.



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.



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

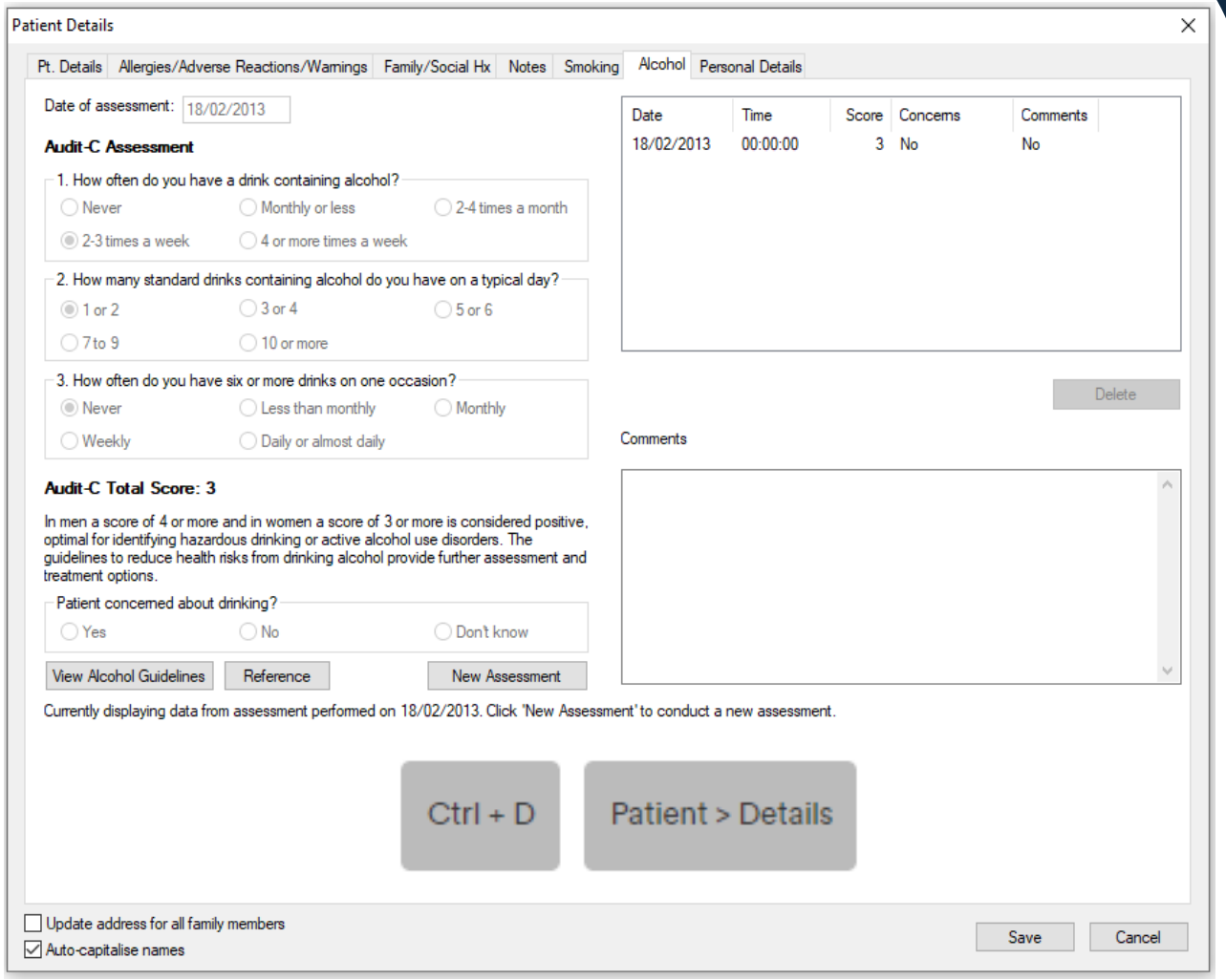
- In men a score of 4 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders.
- In women a score of 3 or more is considered positive (same as above).

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.



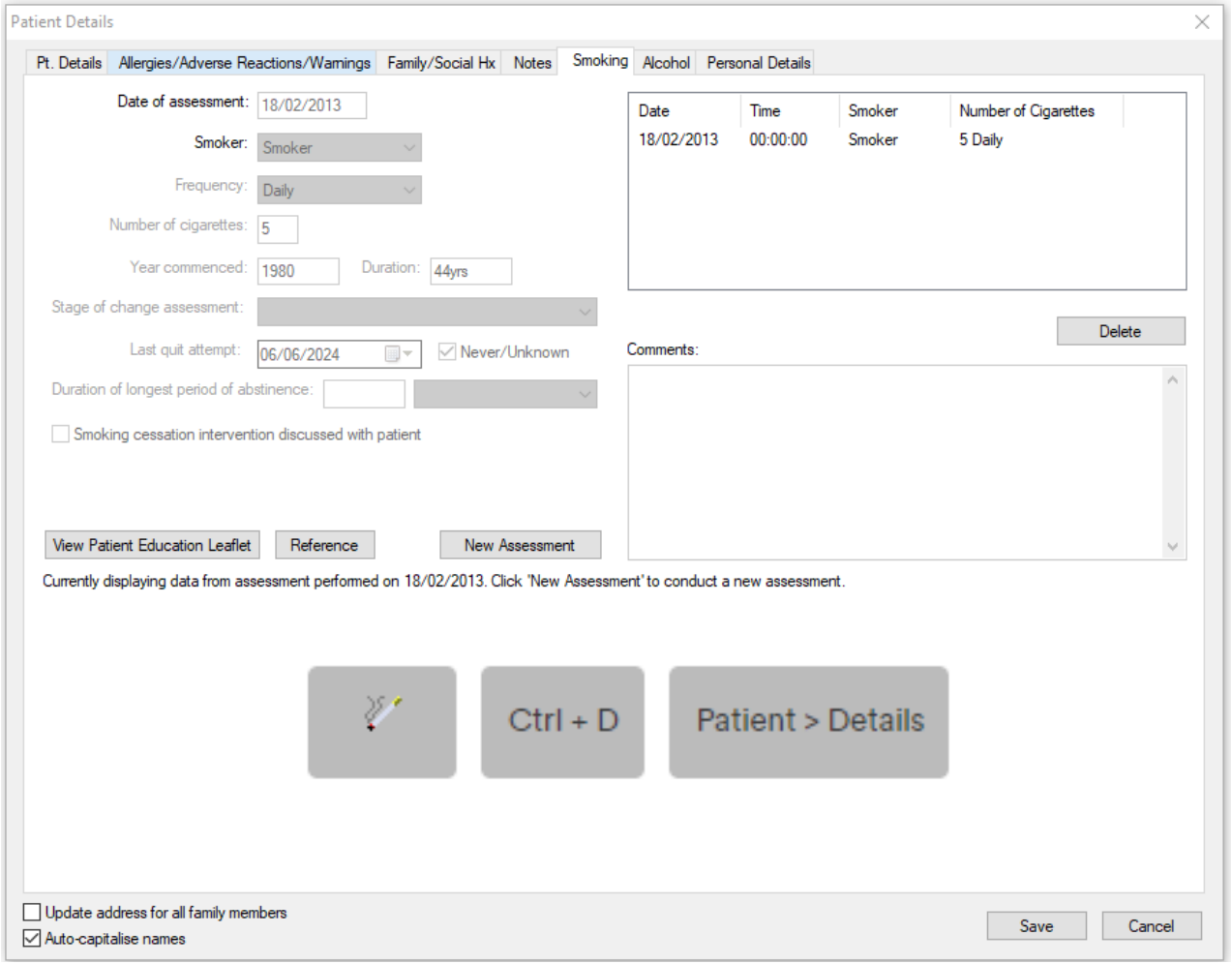
Recording Smoking

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.

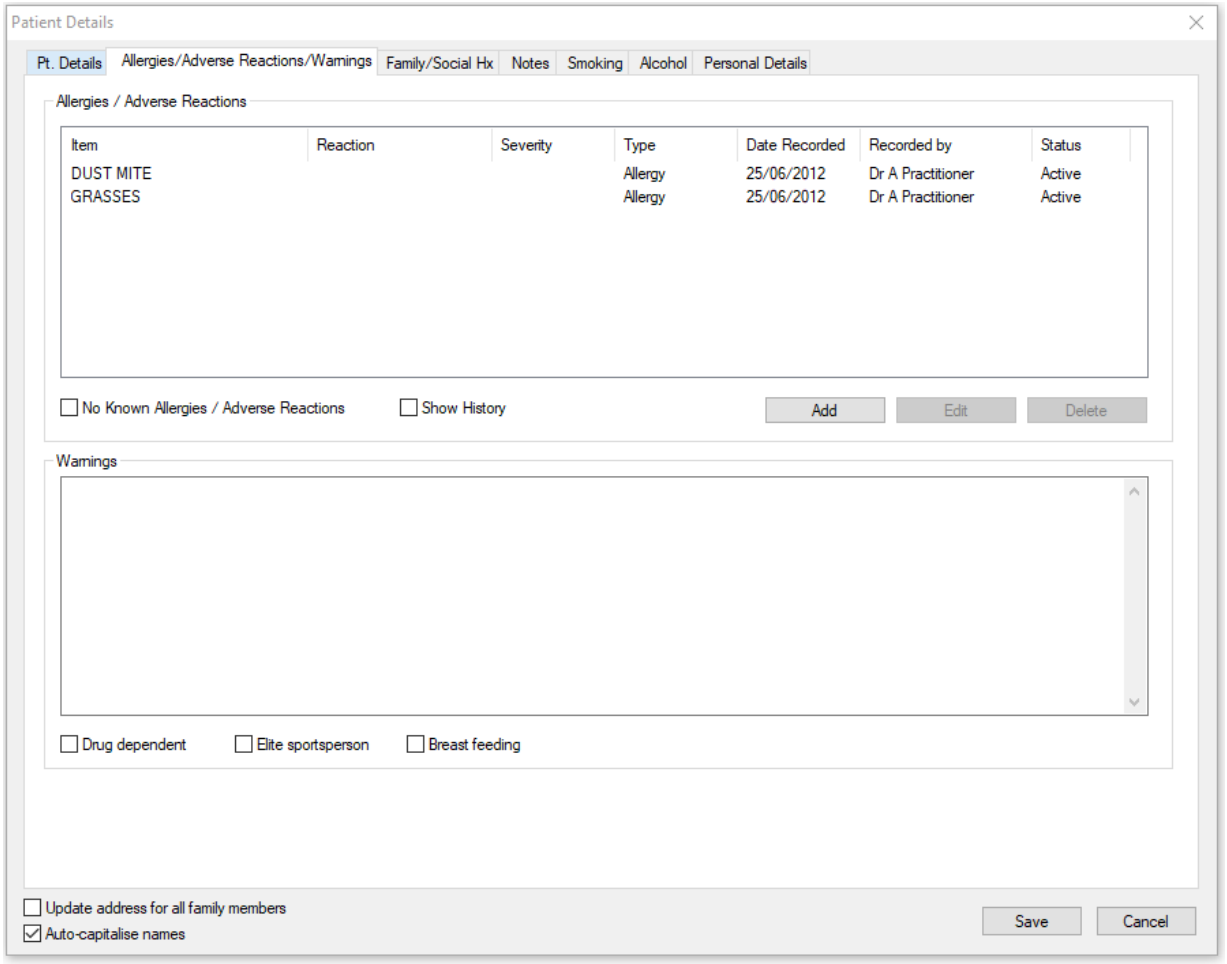
Smoking cessation intervention discussed with patient check box: Ticking this box flags patients for the Smoking Cessation report found in MedicalDirector Insights.

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.



Recording Allergies/Adverse Reactions/Warnings



F7 or Allergies/Warnings (via the Clinical Window)

1. Select the Allergies/Adverse Reactions/Warnings tab within the Patient Details window.
2. Click Add The Add Allergy / Adverse Reaction window appears.
3. Add the source of the allergy:

•Enter Allergy by Drug
•Enter Allergy by Class
•Enter Allergy by Other: Allows you to free-type an allergy not necessarily related to a particular drug or class. You can also use this option to be more specific. For example if you wanted to record an allergy to EXELON you would normally use the 'By Drug' option and simply look for EXELON. However, if the patient was allergic to only the patch variety of EXELON, you could use the 'Other' option instead, and enter 'EXELON Patch'.

4. Describe the nature of the reaction.
5. Indicate the Type of reaction
6. Indicate the Severity of the reaction.

Click OK to confirm your input. Allergies added will be visible at the top-left of the patient's Clinical Window.
To view a percentage of patients who have not been asked about their allergy/adverse reaction status, see Patient's with Non-Entered Clinical Data. You can also print a list of patients from this search utility.

Items of Interest on this window	
No Known Allergies / Adverse Reactions	By ticking this check box you will remove and delete all currently-recorded known allergies and/or drug reactions for this patient. This happens immediately upon ticking the check box, and is not reversible.
Warnings Section	Add free-text warnings to this section. Warnings added will be visible at the top-left of the patient's Clinical Window.
Drug dependent	Ticking this check box will; •Insert an entry into the 'Actions' header of the current Progress Note. •Display "Drug Dependent" on the Warning section in the patient's record.
Elite Sportsperson	This provides warnings when prescribing drugs that are banned in sport.
Breast Feeding	The Breast Feeding check box only appears for female patients within the configured age group.
Update Address for All Family Members	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	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.

Recording reason for visit

The Reason for Contact module allows you to enter a diagnosis into the Progress Notes, using the DOCLE coded list of conditions that is also used in the Past Medical History section of Clinical.

1.Select the Progress tab in the patient's clinical record.

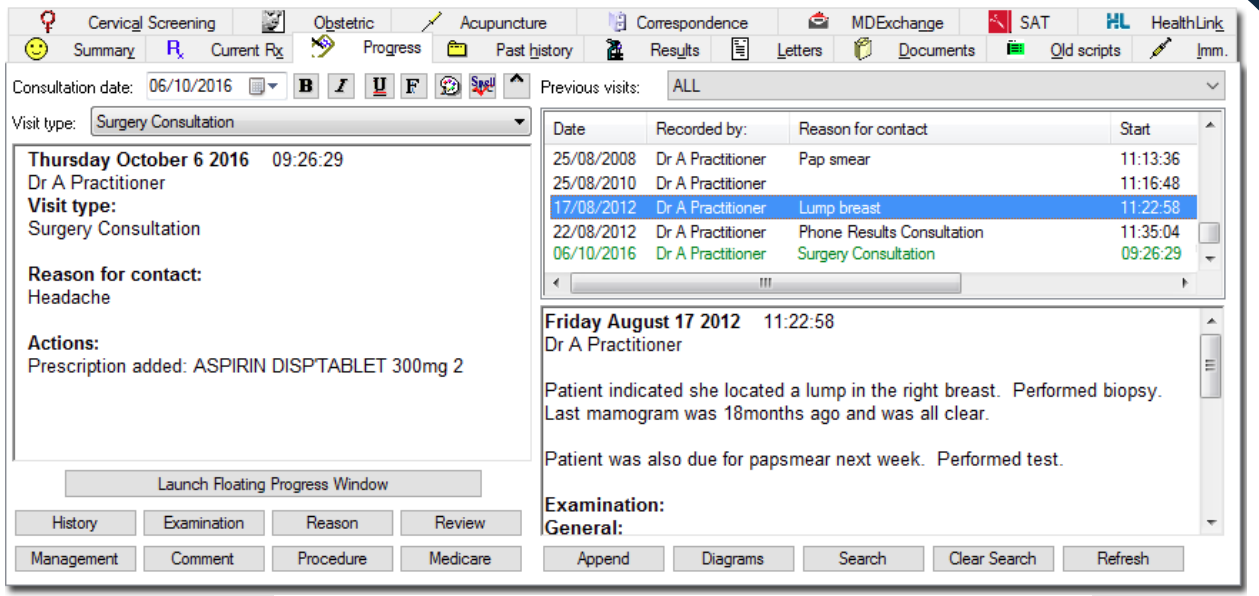
2.Click **Reason** button. The **Reason for Contact** window appears.

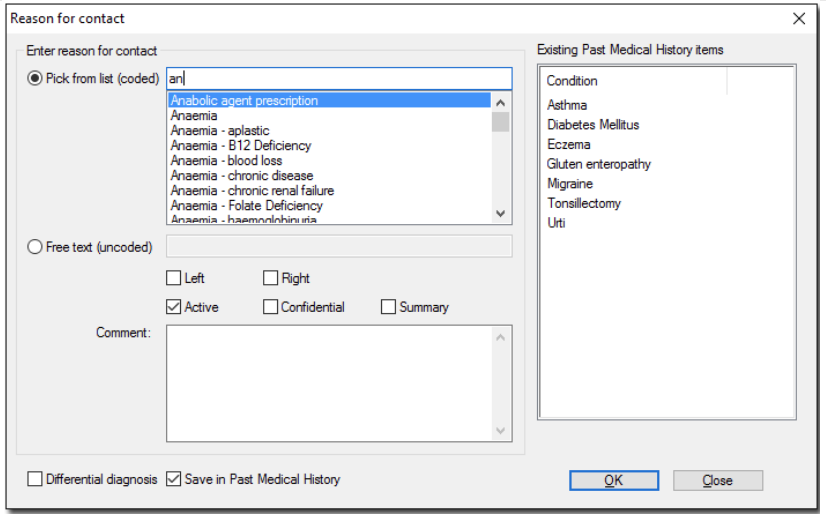
3.Enter the first few letters of the procedure name in the **Pick from List (uncoded)** text box. A list of procedures that start with the letters entered is displayed. The list of procedures changes dynamically as text characters are entered or deleted. Alternatively you can select from previous procedures or conditions listed in the **Existing Past Medical History Items** list.

4.Double-click the required item from the list of choices. Alternatively you can either select from previous procedures or conditions listed in the **Existing Past Medical History Items** list or free-type a **Reason for Contact** into the **Free Text** text box.

5.Optional Modifications:

- By default the procedure is marked as Active. To change this, clear the **Active** check box.
- Select either Left or Right or both to mark whether the procedure is for the Left, Right or both sides.
- By default, the check boxes are set so the record is saved in the Past Medical History list and as the primary Reason for visit. Clear these check boxes if required.
- To list this procedure on printed letters and summaries, select the **Summary** check box.





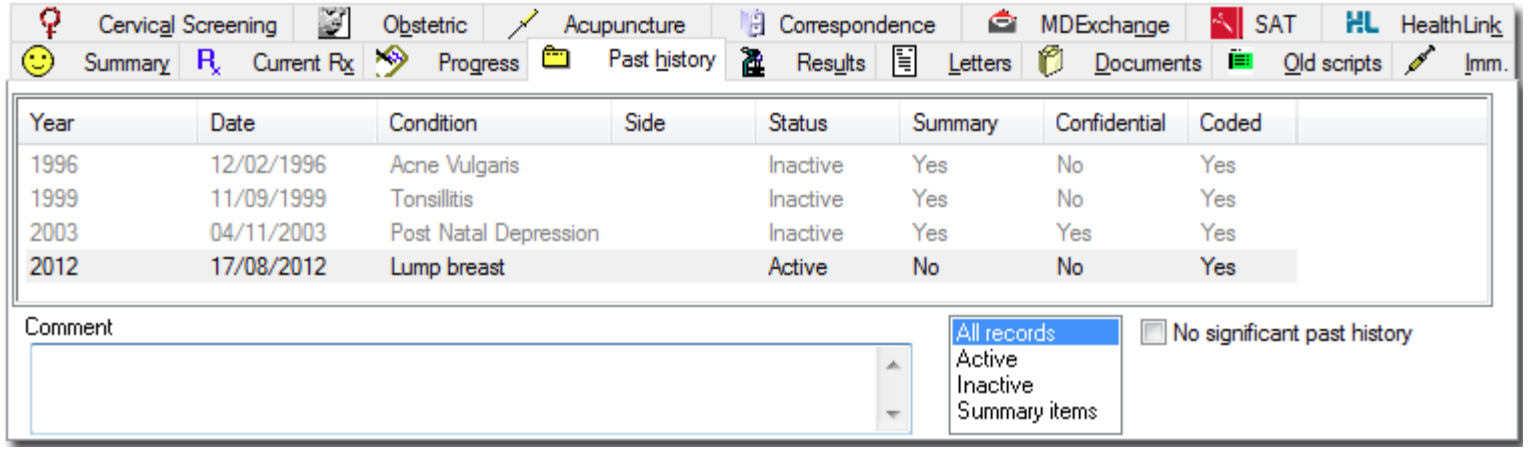
Keeping Past History items relevant

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.

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.

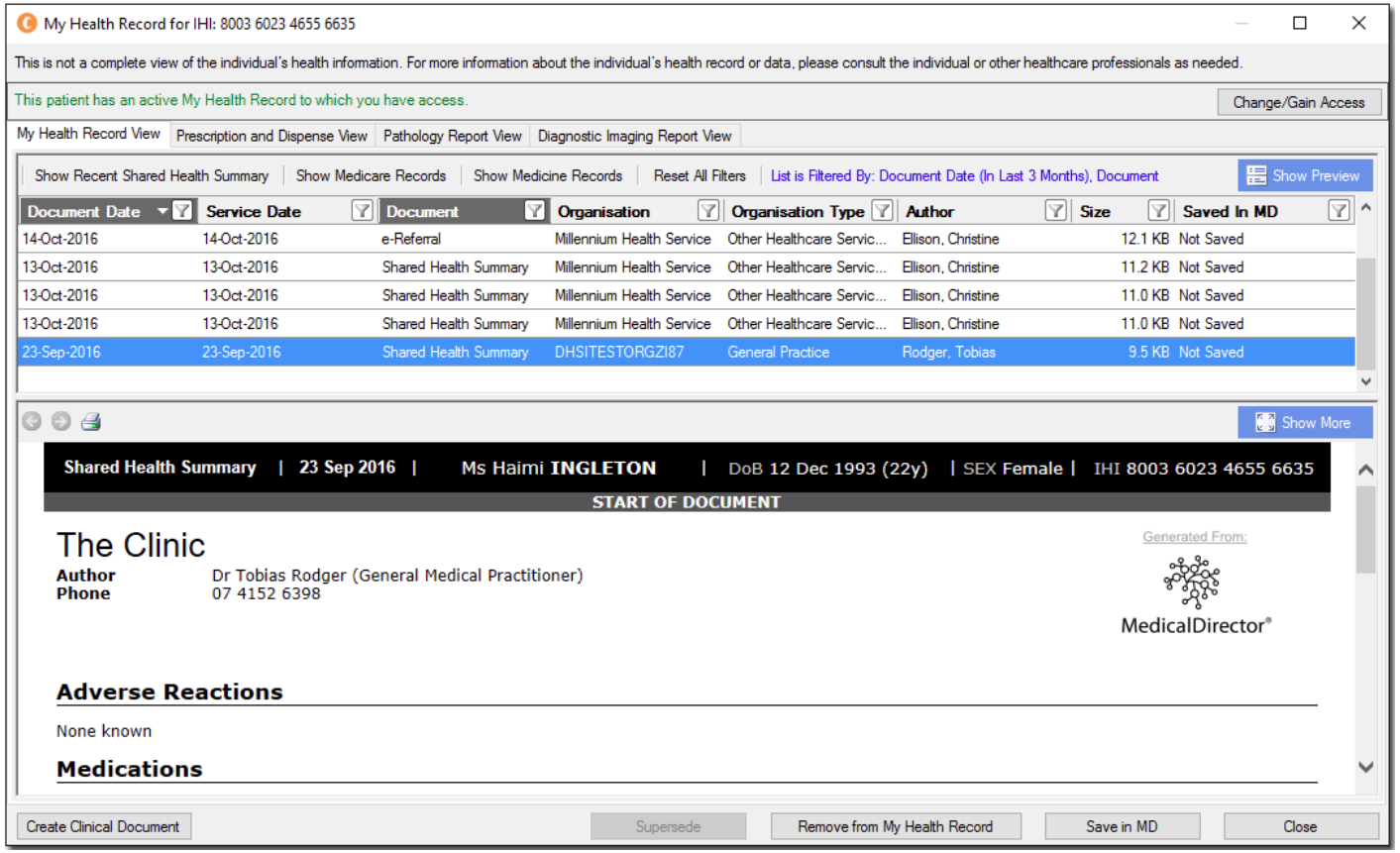
•Code: the document requires an access code to view/download.

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.



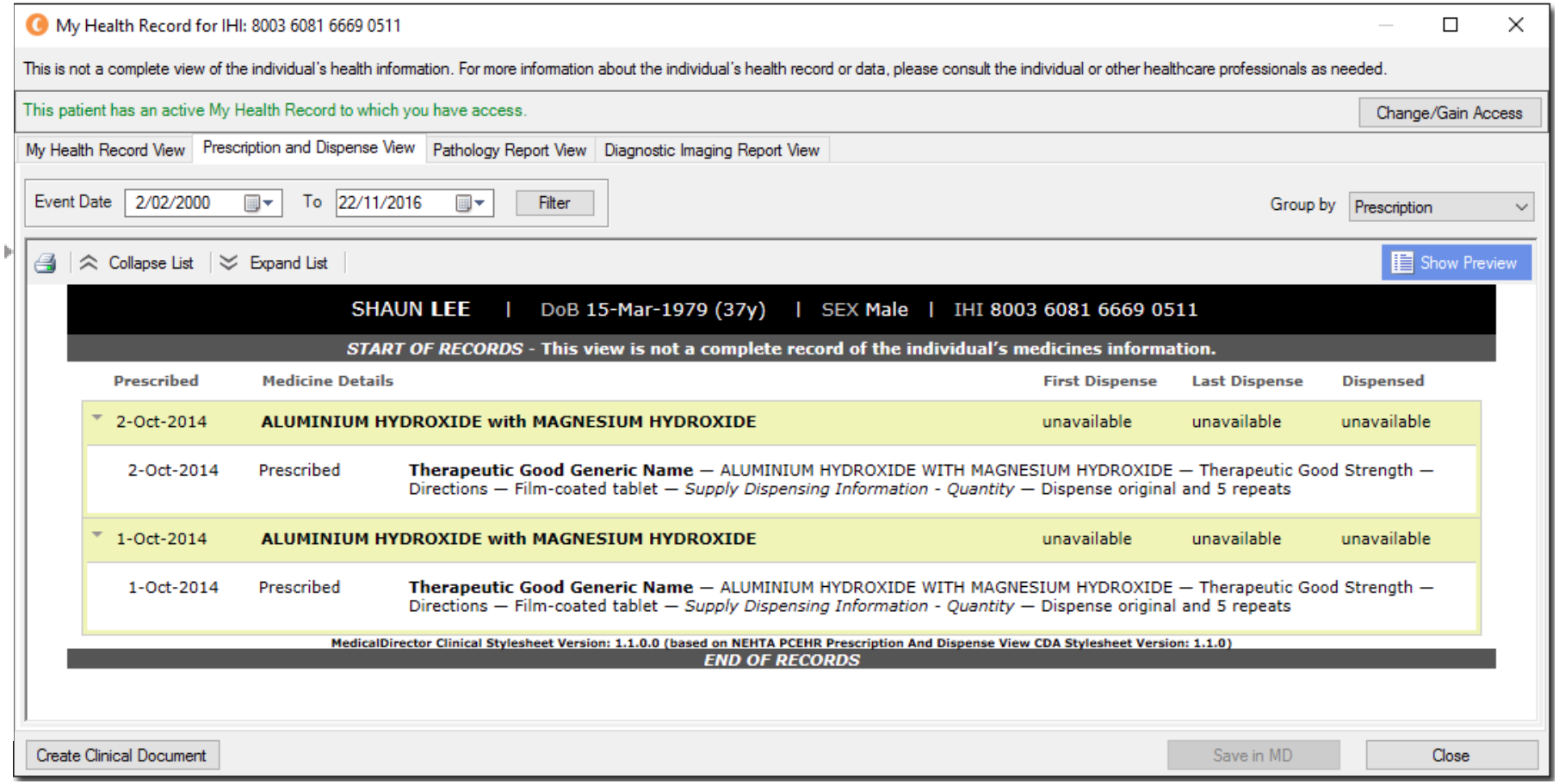
Removes a selected document from the My Health Record system. This is only available if you are the creator of the original document, or it was created by another user from the same Practice (i.e. with the same Practice HPI-O recorded via Tools > Options > Practice tab.

My Health Record accessing Prescription & Dispense

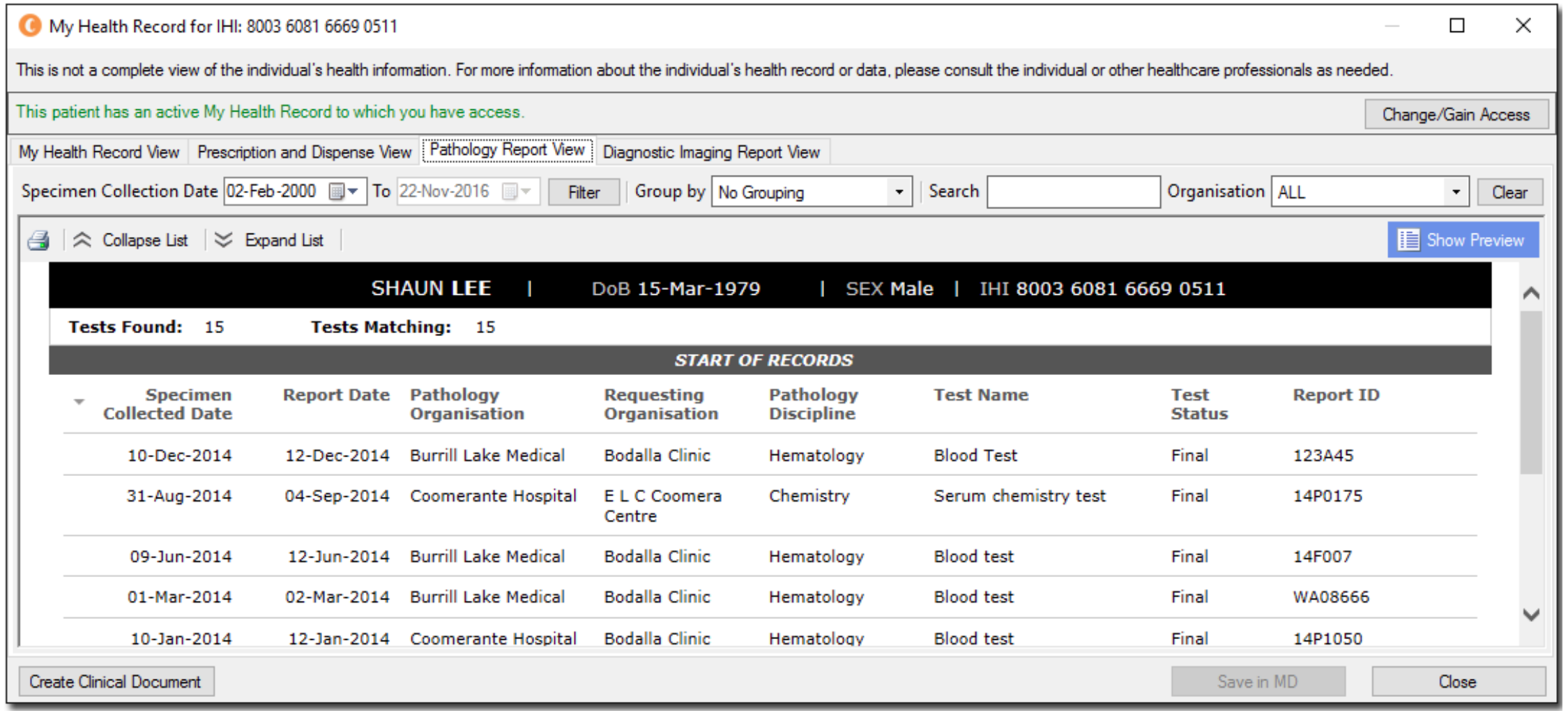
The Prescription and Dispense View tab lists prescribed/dispensed medications that the patient has granted consent to upload to the My Health Record System. Consent is typically indicated via the Enter Dose window during the prescribing process, but can also be granted/revoked afterwards by right-clicking 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;

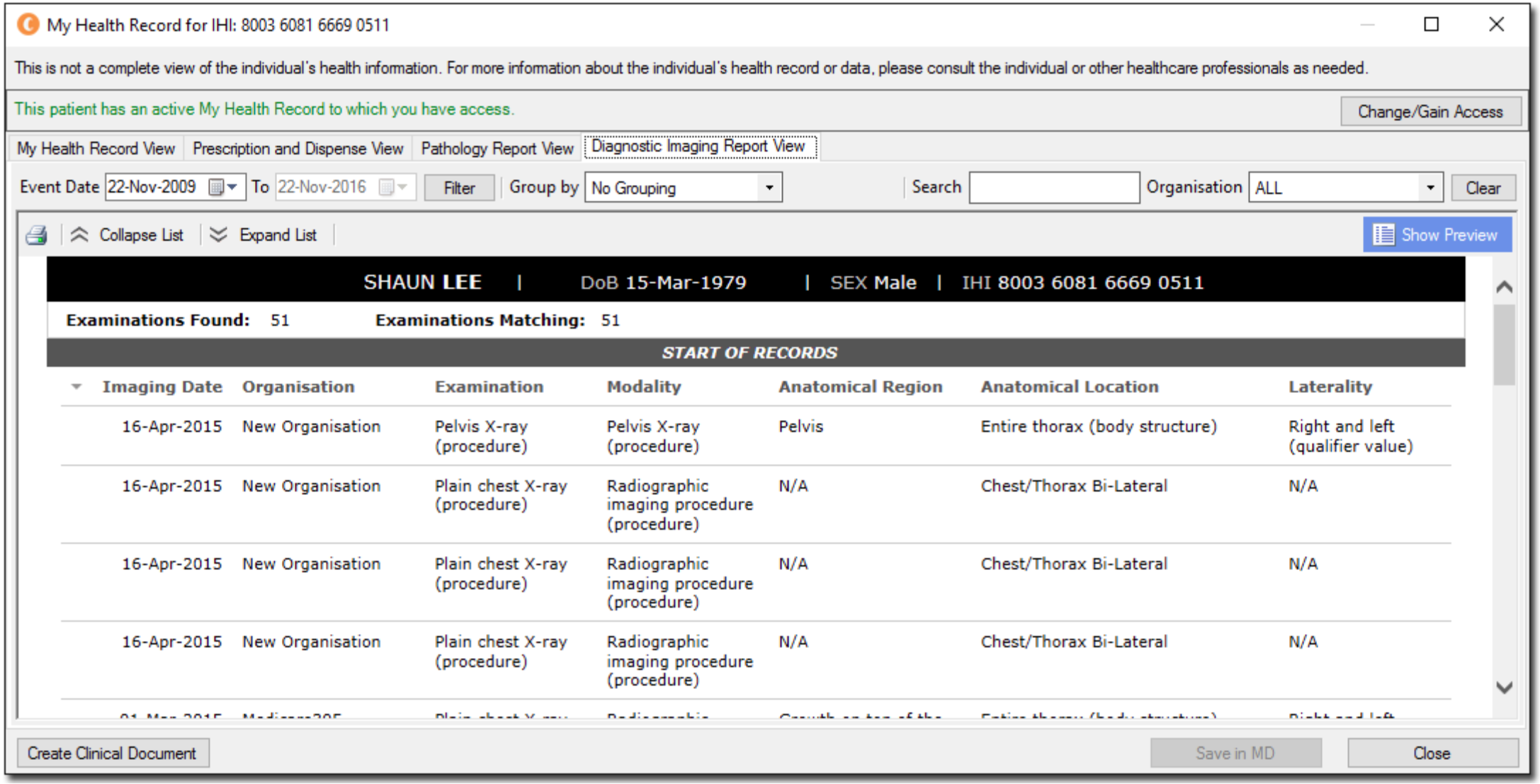
1. First, expand the medication details by clicking the ▸ button at the far left end of the medication row.
2. Secondly, click the medication details. The script details will be revealed



My Health Record accessing Pathology Report



My Health Record accessing Diagnostic Imaging Report



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.

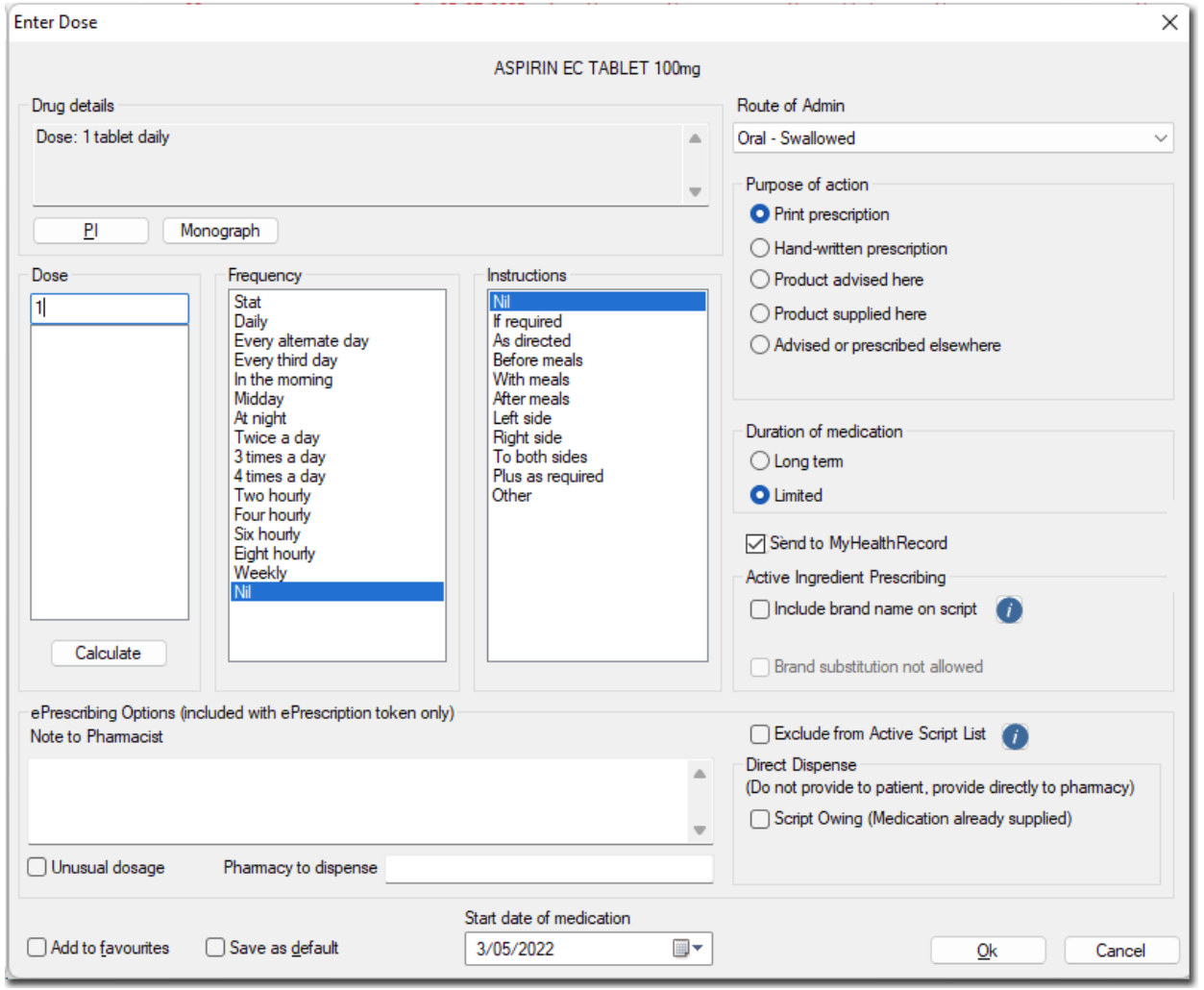
The National Prescription and Dispense Repository (NPDR) is a subset of a patient's My Health Record and allows for the creation of an online medication history (for both prescriptions and dispensing). Transfer of medications in this way requires you are registered for ePrescribing and have enabled eRx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



My Health Record uploading Documents

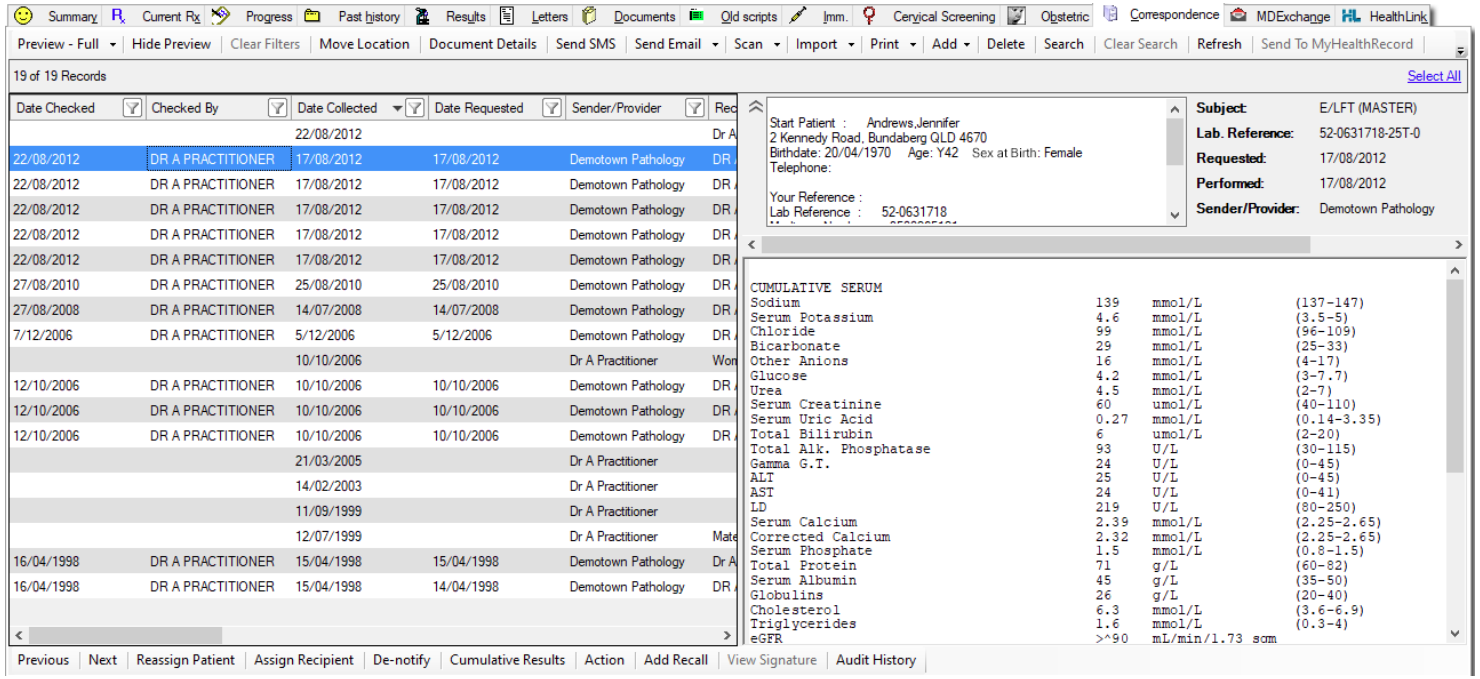
1. Create a CDA document via one of the supplied e-Health templates in Letter Writer.

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.



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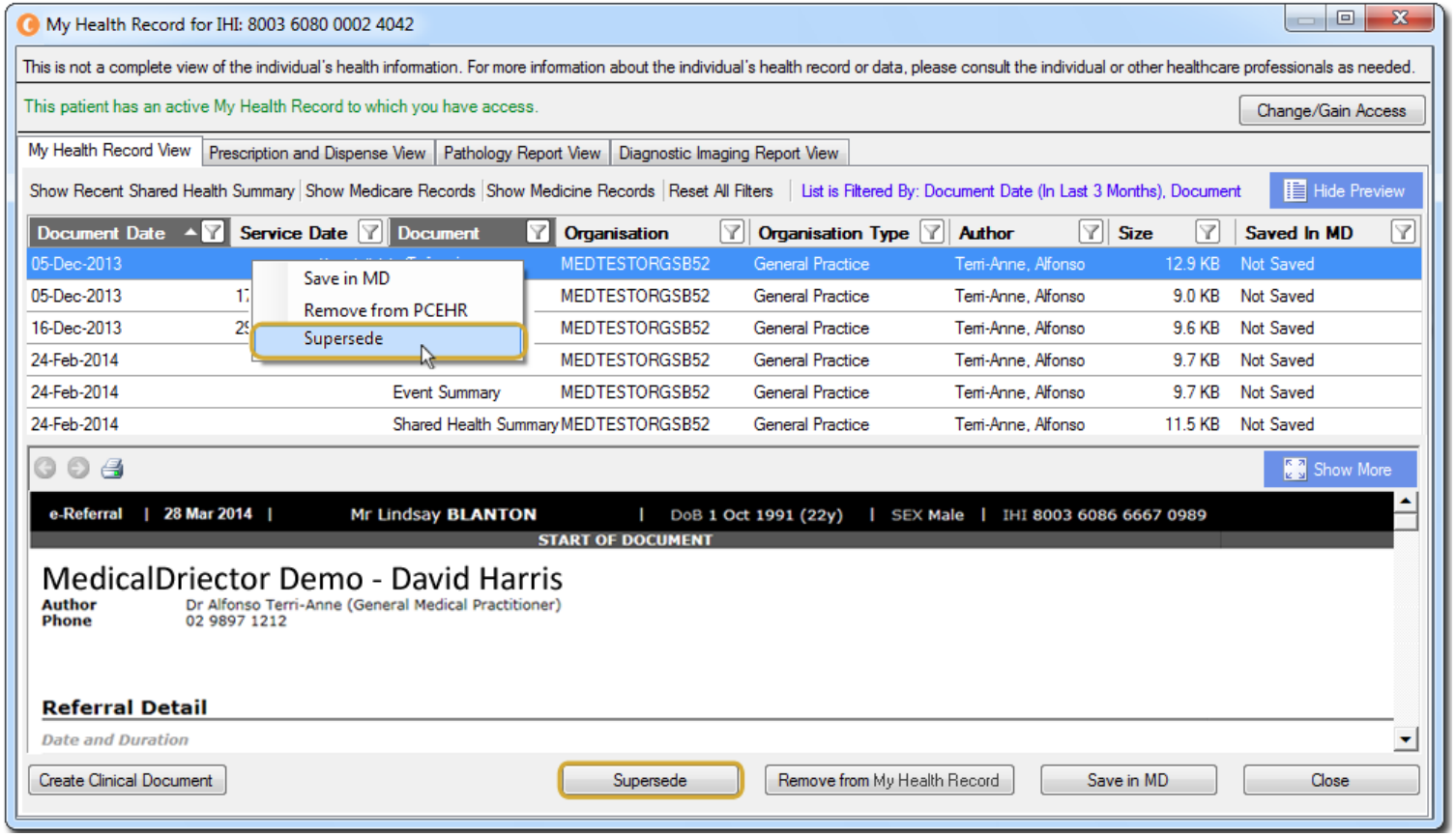
My Health Record Saving, Superseded or Removed

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'.

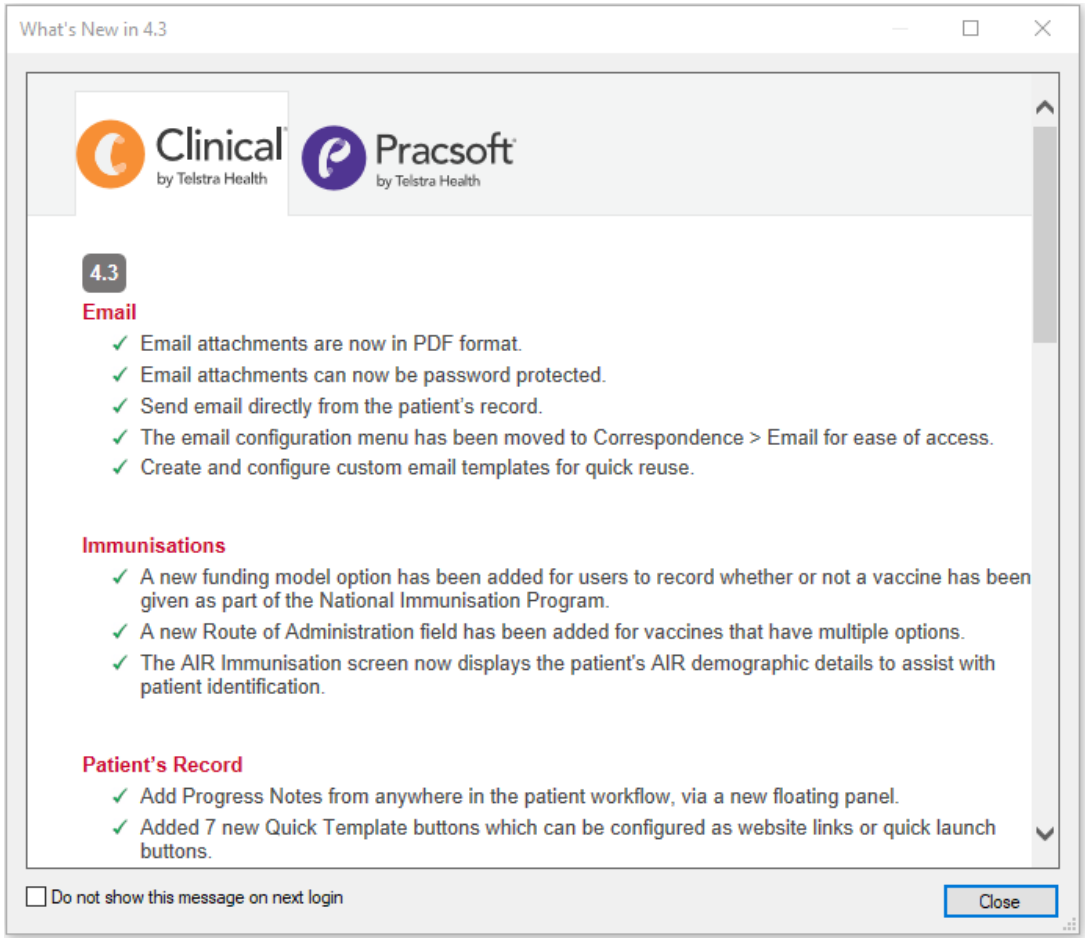
4.3 New Enhancements

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.
When opening the Holding File from within a patient's record, the data is filtered automatically to show results for the selected patient.
· The web URL links in the CVD Risk Assessment screen have been updated to more modern resources.

Prescribing

· You can now search for a drug based on the characters in the search box existing anywhere in the drug name rather than just at the beginning.



· When an Electronic Paperless Prescription with repeats is cancelled after the original has been dispensed, the repeats are now also cancelled.

Email

· Email attachments are now in PDF format.
· Email attachments can now be password protected.
· Send email directly from the patient's record.
· The email configuration menu has been moved to Correspondence > Email for ease of access.
· Create and configure custom email templates for quick reuse.
Improved the loading speed of the holding file when many results are present.

Smart Clinician by Telstra Health

Smart Manager by Telstra Health

Smart Marketplace by Telstra Health

Key features

- Targeted decision support
- Streamline medication orders and deliveries
- Support more patients
- Refer patients the right way
- Everything you need in one place

Introducing Telstra Health Smart Clinician – 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. From Visual Dashboards that provide at-a-glance insights into patient health trends, to Telehealth capabilities that enable virtual consultations, and a Patient Portal ensuring seamless patient engagement. With additional features like Program Finder, Care coordination, Clinical Support, Communications, and Research tools, Telstra Health Smart Clinician stands as an indispensable asset for modern healthcare.

Smart Care

Smart Care makes it easy to set up, populate and review care plans, while promoting compliance with Medicare. Customise templates to suit the needs of your practice and start empowering even more patients to monitor and manage their health.

Smart Clinical Decision Support

Smart Clinical Decision Support utilises AI-driven educational information, empowering clinicians to make informed decisions efficiently. Each concise, structured message focuses on early detection and preventive measures for chronic illnesses in patients.

Smart Research

Smart Research makes it easy for you to access the latest medical research and clinical knowledge from anywhere, anytime.

Smart Visual Dashboards

Smart Visual Dashboards provide intuitive practice insights, reducing wait times and improving patient experiences. Our revenue reporting tool forecasts income, cuts admin overheads, transforming healthcare practices.

Smart Telehealth

Smart Telehealth integrates into your clinical workflow, enabling practitioners to access patient health records within MedicalDirector Clinical and Helix. Simplify processes for better care remotely.

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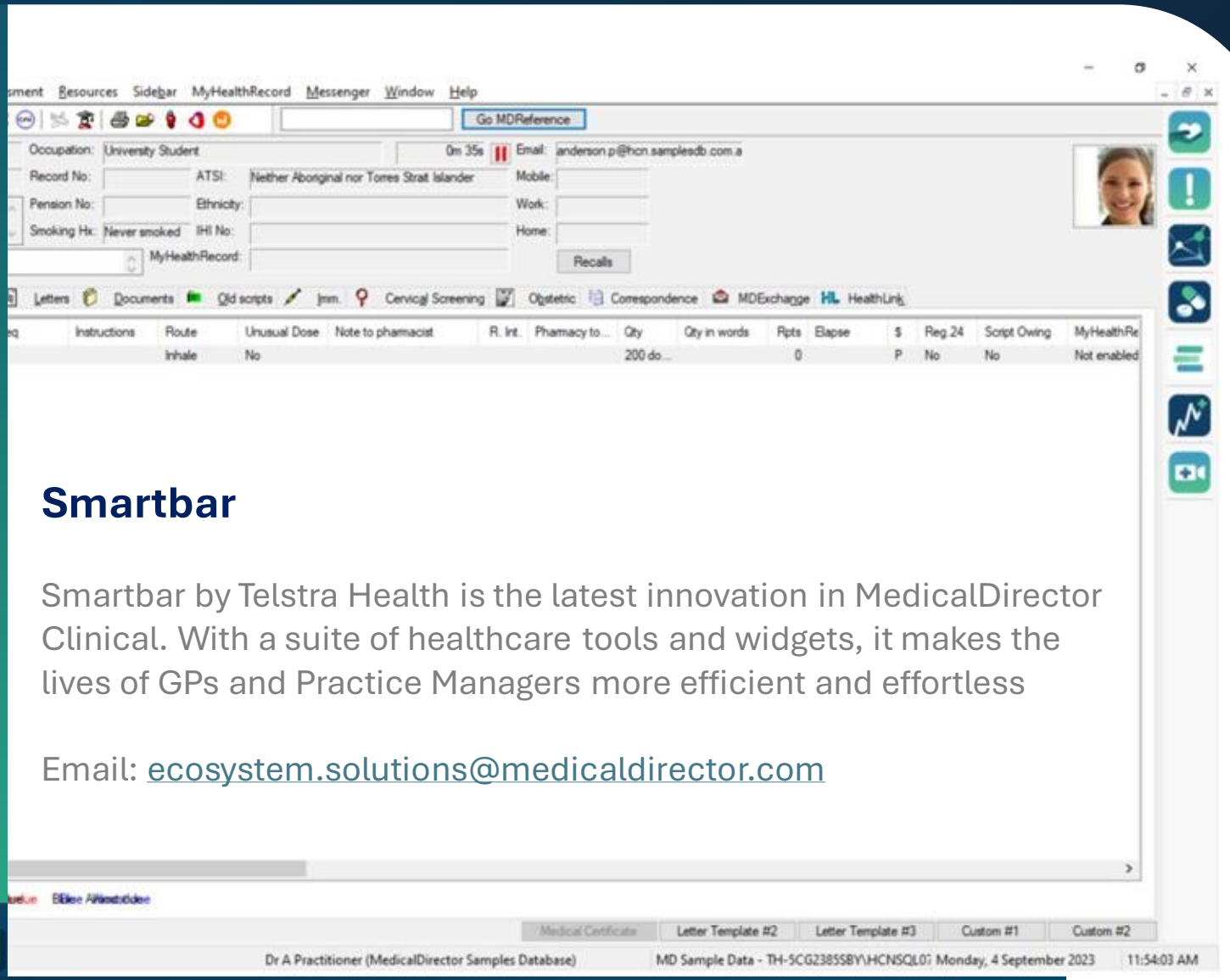
Smart Bar - Tools available in Smart Clinician



Smartbar

Smartbar by Telstra Health is the latest innovation in MedicalDirector Clinical. With a suite of healthcare tools and widgets, it makes the lives of GPs and Practice Managers more efficient and effortless

Email: ecosystem.solutions@medicaldirector.com

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FAQ'S

Q1. Trouble shooting uploading shared summaries to my health record. Why do some not work?

Answer:

Regarding the issue with viewing **Discharge summaries\Uploading to My Health Record**, please do the following;Press the Windows key and R

•Browse to; C:\windows\assembly\GAC_32 (you can only get there by browsing)

Add:

•C:\Windows\Microsoft.NET\assembly\GAC_32\Hcn.Cda.Generator\v4.0_1.0.0.0__d6b06804ccddbb90\Hcn.Cda.Generator.dll

•C:\Program Files (x86)\Health Communication Network\Medical Director\Plugins\Hcn.Sidebar.Plugin\FiddlerCore.dll

In the Sophos dashboard, please add the general exception and exceptions for each individual PC as well.

Each of the DLLs may require re-application after this has been applied.

May require a repair of the MedicalDirector National eHealth plugins and the MedicalDirector sidebar plugin

Open Control Panel > Programs and features

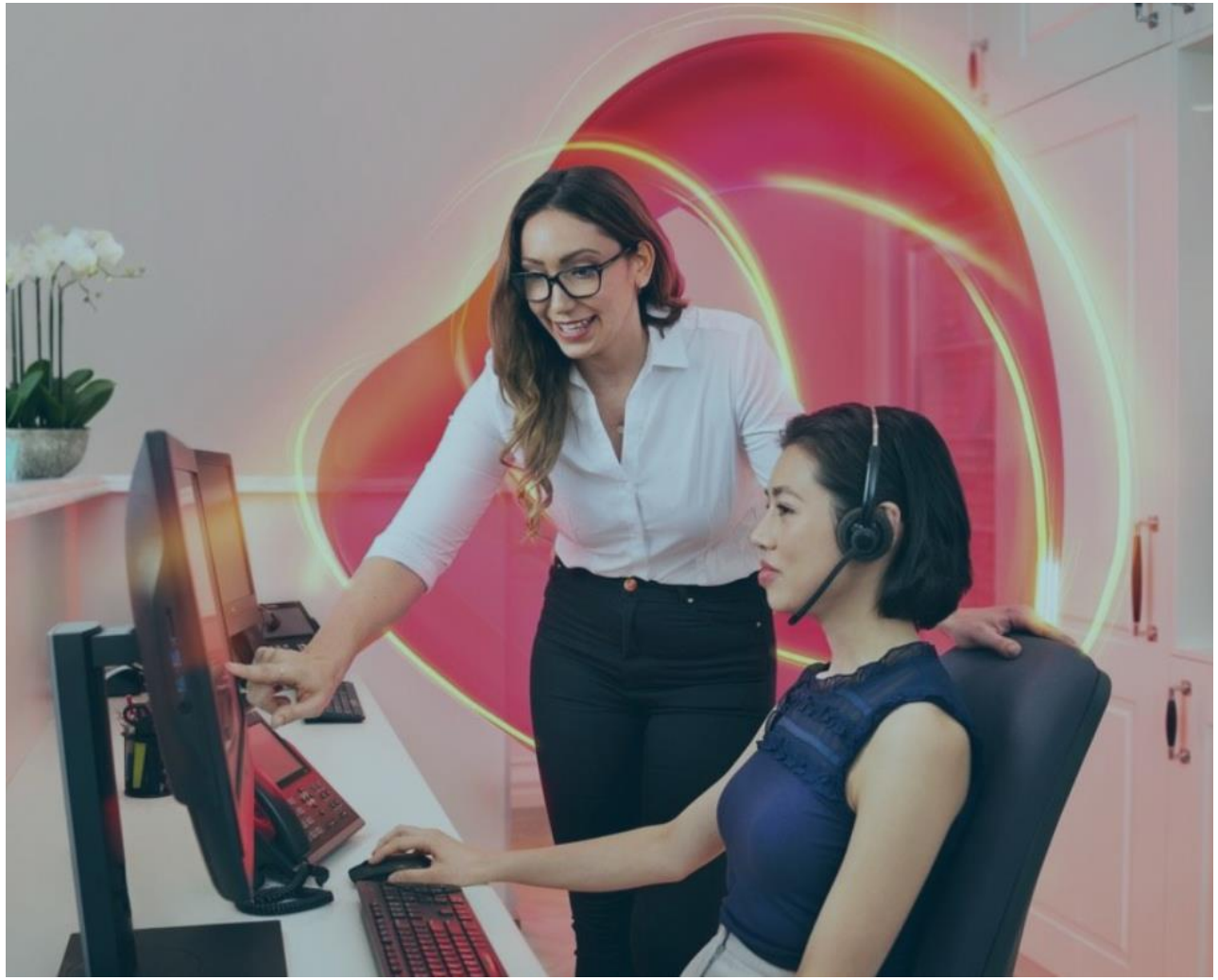
Find the program and right click and repair

Check Firewall Rules for MedicalDirector Software

Antivirus Exceptions for MedicalDirector Software

Environmental Configurations for MedicalDirector Services

Your Support Team



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Contact

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P: (03) 9046 0300

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MedicalDirector Resources

Clinical and Pracsoft version 4.3: The latest upgrade of Telstra Health's GP software
Harnessing the power of your practice data
Introducing MedicalDirector Care – Making Care Plans easy
Preparing your practice for ePrescribing
Introducing Telehealth in MedicalDirector Clinical

MyMedicare resources:

Australian Government Department of Health and Aged Care – MyMedicare
MyMedicare webinar – 22 August 2023 | Australian Government Department of Health and Aged Care
Services Australia MyMedicare Learing Resource
Services Australia Checklist and steps to register for MyMedicare on the Organisation Register
Information for patients on MyMedicare – Australian Government Department of Health and Aged Care
MyMedicare – Health Professional Education Resources
MyMedicare – Overview
MyMedicare – Managing patient registrations
MedicalDirector Clinical and Pracsoft version 4.3 upgrade
MyMedicare Import Wizard for Clinical version 4.3

Upcoming Webinars

MedicalDirector Training for Clinical Nurses

Dates: Time: Location: Enquiries:
Wednesday 7 August 2024 12pm - 2pm Online webinar Digital Health digitalhealth@emphn.org.au

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

Register using the QR code or visit
www.emphn.org.au/newsevents/events/detail/25920

MedicalDirector Training for Advanced Practice Managers

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

- 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

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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

MedicalDirector | Health Primary, Aged & Community Care

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