

Medical Director 3 - Module 5

Incoming Pathology and Electronic Documents

October 2012

Contents

| Topic | Page |
|---------------------------|------|
| What changed in 3.14a | 3 |
| Workflow Choices | |
| Electronic Pathology | 4 |
| Discharge Summaries | 4 |
| Unchecked Hard Copy | 5 |
| Checked Hard Copy | 5 |
| The Holding File | 6 |
| More | 7 |
| Action or No Action | 7 |
| Actioned Items | 8 |
| More | 9 |
| Notification | 9 |
| Scanning Workflow Choices | 10 |
| Importing | 11 |
| The Patient Record | 12 |

DISCLAIMER: Whilst every reasonable effort has been made to ensure that the information given in this document is accurate, Tasmania Medicare Local will not accept liability for any injury, loss or damage arising directly or indirectly from any use of or reliance on this information.

Incoming Pathology and Electronic Documents

What Changed in MD 3.14a

Although this document is intended as a comprehensive guide to how MD manages electronic documents, it was pre-empted by the significant changes brought about by the release of MD 3.14 and the subsequent 3.14a update. If you only want a summary of what changed with these releases, see below:

HCN Maintenance

Document Holding Bay no longer exists ManageEzy tab removed from Configuration Utility

Front Screen

The Investigations menu is now called Correspondence ^a The Investigation Results screen is now called Actioned Items ^a There is now a facility to scan to the MD Holding File, under File...Scan/Import Correspondence

Holding File

Far greater control over display of results collectively and individually Ability to specify eventual storage destination of document in patient record Follow-up categories not restricted to *No Action, Discuss, Return Urgently* Ability to reassign result at patient or GP level Ability to assign follow-up actions to non pathology documents Ability to view *Audit History* of document Html documents now print (e.g. rhh electronic discharge)

Actioned Items

Far greater control over display of results collectively and individually Ability to change eventual storage destination of document Ability to reassign result at patient or GP level Access to scanning and importing functionality Ability to view *Audit History* of document Html documents now print (e.g. rhh electronic discharge)

Patient Record

Far greater control over display of results collectively and individually Easy movement of items between *Results*, *Documents* and *Letters* tabs Introduction of *Correspondence* Tab showing "all in one" view of *Results*, *Documents* and *Correspondence* tabs
Ability to scan or import from all 4 document related tabs.
Automatic prompt when new Investigation results available
Html documents now print (e.g. rhh electronic discharge) *Letter Writer* can now create CDA format documents

^a3.14a Update

Overall Concept

Far greater control over the handling, viewing and storage of all electronic documents.

Availability of scan/Import buttons from multiple locations cater for staff with differing access levels.

Workflow Choices

This module contains detailed information on each or the relevant screens used for processing patient clinical information received from an external source. In the main there are 4 workflow scenarios that cover the majority of situations. They are summarised below.

Electronic Pathology

Electronic Pathology/Radiology Results

Client Program running on practice computer periodically checks Pathology/Radiology Laboratory messaging service and downloads appropriate results to MD *Holding File*.

GP Periodically checks *Holding File* via *Correspondence* .. *Check Holding file*, from either the front screen, or within the patient record.

GP views the result and can optionally:

- ♦ Add a Recall
- ♦ Add a Smear result
- ♦ Mark off an Outstanding Request
- Change the end storage location in the patient record

GP flags/details the level of follow-up action required.

Result is removed from Holding File and is stored in the patient record

Result and GP follow -up instructions are now available to practice staff via *Correspondence ..Actioned Items* from the front screen

Practice staff perform appropriate follow-up tasks

When the GP discusses the pathology result with the patient, it is marked as Notified

Electronic Discharge Summaries

Electronic Discharge Summary/Specialist Letter or Report

Client Program running on practice computer periodically checks Hospital or Specialist messaging service and downloads appropriate documents to MD *Holding File*.

GP Periodically checks *Holding File* via *Correspondence* .. *Check Holding file*, from either the front screen, or within the patient record.

GP views the document and can optionally:

- ♦ Add a Recall
- ♦ Change the end storage location in the patient record

GP flags/details the level of follow-up action required.

Document is removed from Holding File and is stored in the patient record

Document and GP follow -up instructions are now available to practice staff via *Correspondence ..Actioned Items* from the front screen

Practice staff perform appropriate follow-up tasks

Workflow Choices

Unchecked Hard Copy

Unchecked Hard Copy Documents or pdf/word files.

Practice staff member accesses File.. Scan/Import Correspondence from the front screen

Practice staff member selects either Scan (paper) or Import (File)

Practice staff member completes scan/import and completes Document Details screen with some or all of the following information:

> **Document Date** Patient Name Allocated GP

Document - Type

- Subject - Location
- Details

Document is transferred to the Holding File and remains visible under File.. Scan/Import Correspondence

GP Periodically checks Holding File via Correspondence .. Check Holding file, from either the front screen, or within the patient record.

GP views the document and can optionally:

- ♦ Add a Recall
- Change the end storage location in the patient record
- Modify the document details

GP flags/details the level of follow-up action required.

Document is removed from both the Holding File and File.. Scan/Import Correspondence and is stored in the patient record

Document and GP follow -up instructions are now available to practice staff via Correspondence .. Actioned Items from the front screen

Practice staff perform appropriate follow-up tasks

Checked **Hard Copy**

Checked Hard Copy Documents or pdf/word files

Practice staff member accesses Correspondence .. Actioned Items from the front screen, or any of the Documents/Resuts/Letters tabs within the patient record

Practice Staff member selects either Scan (paper) or Import (File)

Practice Staff member completes scan/import and completes Document Details screen with some or all of the following information:

> **Document Date** Patient Name Allocated GP

- Document Type
 - Subject - Location

 - Details

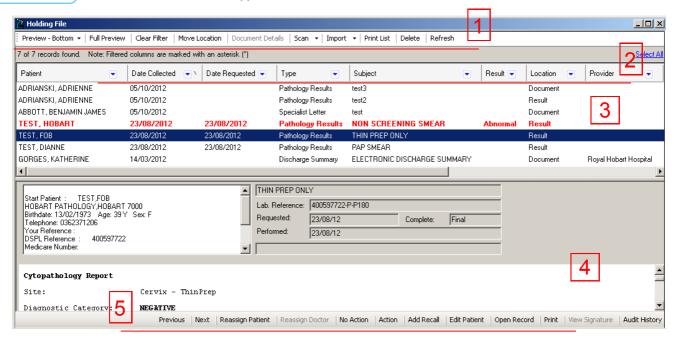
Upon completion of the Document Details the document is immediately stored in the Patient record in the selected section.

Practice staff perform appropriate follow-up tasks as manually directed by the GP

The Holding File

The Holding File

The GP periodically checks for incoming pathology or correspondence by accessing the *Holding File* via *Correspondence ..Check Holding file*, from either the front screen, or within the patient record. The screen will be similar in appearance to the one below.



- 1: Top Buttons. From here you can:
 - Control the location of the *Preview* window, Bottom, Right or off altogether.
 - · Toggle between full and partial preview
 - Clear all filtering selections you have made from the Column Headings
 - Move the storage destination of the item between results/documents etc
 - Edit the Document Details of a scanned or Imported Document
 - Print a list of items as well as Scan/Import/Delete a document
- 2: Column Headings. Lots of ways to fine-tune the display of results including:
 - Using the downward arrows you can narrow down or filter the displayed results by;
 Date Collected, Document Type, Document Source or any other category related to the column heading.
 - Clicking on the column headings will sort the displayed documents in alternately
 ascending or descending order. e.g. Clicking on the *Patient* column heading will sort the
 documents in Patient surname order. Similarly clicking on the *Date Collected* column will
 sort the documents in chronological order.
 - By clicking and dragging from right to left, or left to right, you can change the order the columns appear in on your screen.
 - By clicking and dragging on the Column Heading edges you can resize the columns to accommodate your preference, and screen size/resolution
- 3: List of Results or Documents. Results and Documents available for checking appear here.
- **4: Document Preview.** The preview screen can be resized by either clicking and dragging on the top edge, or the leftmost edge, depending whether the preview screen has been set to bottom, or right of screen.
- 5: **Bottom Buttons.** These are only visible if you have the preview window enabled, and set wide enough to reveal all the buttons. From here you can:
 - Specify what follow-up actions (if any) you want for the item
 - Assign the item to another GP or Patient.
 - Add a Recall
 - Open the patient record
 - Print the item or view the Audit History

The Holding File

More about The Holding File

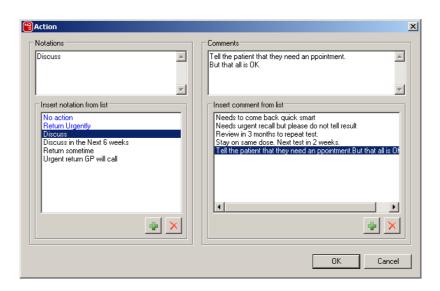
There are some other useful things to know about the *Holding File*:

- From the menu File..Add Smear Result you can record the outcome of a cervical smear directly to the patient record
- From the menu *File..Outstanding Requests*, you can mark of pathology requests that you are confident have been returned. (See Module 4, Page 10 for more information).
- You can select all items for printing by clicking on the Select all link at the right of screen
- You can manually select items by using a combination of the mouse and the Ctrl or Shift keys
- Any filter selections you make are specific to your login and will still be in place the next time you check the *Holding File*. Quickly reset all the filters to default by clicking the *Clear Filter* button at the top.
- If MD cannot find a patient that matches with the header information of the item, you will be
 prompted to select one from a list, or add a new patient based on demographic information from
 the result
- If MD finds an identical item already stored in the system, it will ask if you want to replace the
 existing item with the current item.

NB: It is definitely worth spending some time customising this screen to suit your work habits and preferences. Rearranging and resizing columns and specifying the preview location and sort orders as well as filtering will all contribute to smoother work processes,

Action or No Action

By selecting the *Action* or *No Action* button, the GP specifies what follow-up is to be done for the item. From MD 3.14 onwards the practice is no longer limited to the 3 follow-up categories of *No Action, Discuss* or *Return Urgently*. The practice is now able to set up as many categories for result follow up as is necessary, as well as have a defined list of comments which can be easily selected, as per the graphic below.

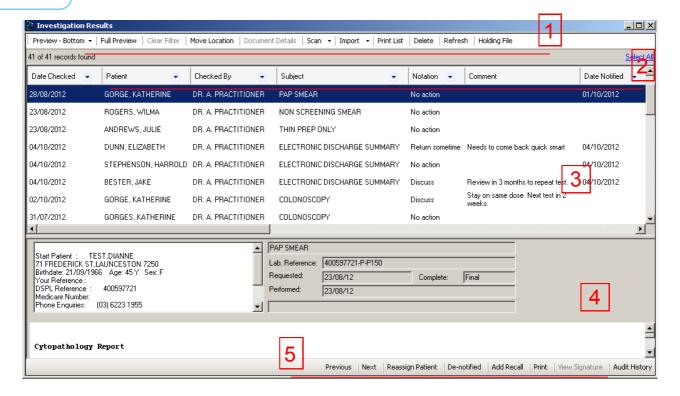


So both the Action *Notation* and the *Comments* can be either selected from the lower box or manually typed into the upper box. If you type into the upper box and want to save the notation/comment for future use, just click on the green "plus" button. Conversely selecting an item in the lower area and clicking the red cross will delete it from the list.

Whilst a greater choice of notation options, and the ability to add comments are effective ways of communicating follow-up requirements, it is helpful to ensure that all staff have a common understanding of the intent behind each notification category.

Actioned Items

Actioned Items Screen This screen is accessed from the *Correspondence..Actioned Items* menu, and is the key screen for monitoring documents that have been **Actioned by the GP** and ascertaining any follow-up require ments. Items will **only** appear here after they have been checked by the GP. This screen is very similar in layout to the *Holding File*.



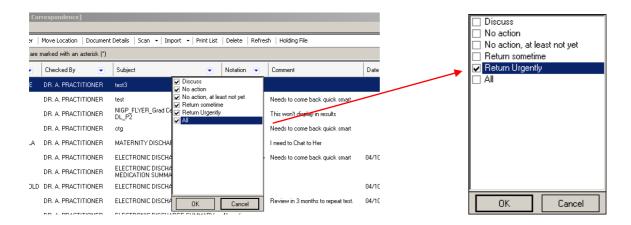
- 1: Top Buttons. From here you can:
 - Control the location of the *Preview* window, Bottom, Right or off altogether.
 - · Toggle between full and partial preview
 - Clear all filtering selections you have made from the Column Headings
 - Move the storage destination of the item between results/documents etc
 - Edit the Document Details of a scanned or Imported Document
 - Print a list of items as well as Scan/Import/Delete a document
- 2: Column Headings. Lots of ways to fine-tune the display of results including:
 - Using the downward arrows you can narrow down or filter the displayed results by;
 Date Checked, Notation, Item type etc
 - Clicking on the column headings will sort the displayed documents in alternately ascending or descending order.
 - By clicking and dragging from right to left, or left to right, you can change the order the columns appear in on your screen.
 - By clicking and dragging on the Column Heading edges you can resize the columns to accommodate your preference, and screen size/resolution
- 3: List of Checked Items. Checked documents appear here.
- 4: Result Preview. The preview screen can be resized by clicking and dragging...
- 5: **Bottom Buttons.** These are only visible if you have the preview window enabled, and set wide enough to reveal all the buttons. From here you can:
 - Mark a result as notified
 - · Assign the item to another Patient.
 - Add a Recall
 - Print the item or view the Audit History

Actioned Items

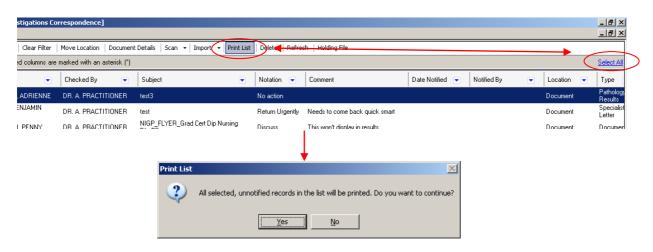
More about Actioned Items

Practice staff will often print hard copy lists from this screen. These are the steps to ensure that the printout contains only the information you require.

1) Use the *Filter* arrow on the *Notation* Column Heading to narrow the list down to a specific follow-up category. The example below illustrates the steps for specifying a *Return Urgently* list.



2) Click on Select All followed by Print Lists from the Top Buttons.



- 3) As the dialogue box says, all selected unnotified results will be printed. If you want to select or unselect items without using the Select All link, you can manually select using the mouse and either the *Ctrl* or *Shift* keys.
- **NB**: When you print the list, you will be asked: "Do you wish to mark these patients as being notified* Generally speaking, Items should only be marked as Notified if a clinician has discussed the item with the patient. Your practice however, may have a specific process that means it is ok to say "Yes" to this question. As with any of the instructions in this manual, they are to be used in conjunction with your documented practice protocols and systems.

Notification

The *Notify* button is to be found on the bottom row of buttons. The person authorised to discuss the outcome of the item (usually pathology test) should mark the item as being *Notified* to the patient. MD will automatically record the name of the notifier as well as the date of notification. This function can also be done from within the patient record under the *Results/Documents* tabs, and is an important component in the practice's demonstrable system of pathology follow-up. In short, it completes the cycle that commenced when the clinician requested the pathology test.

If a result is accidentally marked as *Notified*, there is a *De-notified* button on the same row. It can only be used however on the same day the mistake was made.

Scanning

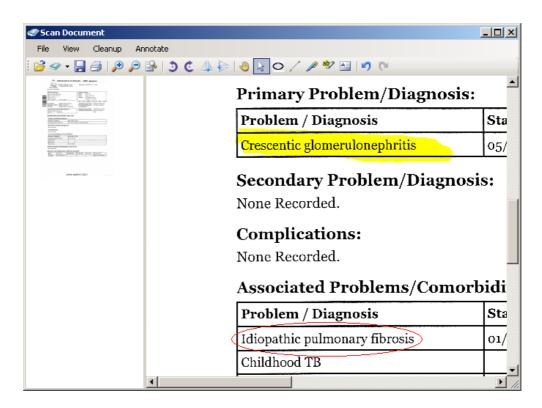
Scanning Workflow Choices

Your scanner can be accessed from multiple locations within Medical Director. There are probably three different workflow choices that will effect where you choose to access the scanner from:

- 1) **Unchecked Documents**. As the name implies these are documents that haven't been seen by the GP yet. To scan these documents to the GP Holding file for checking and possible flagging for follow up, go to *File..Scan/Import Correspondence*.
- 2) Checked Documents Multiple patients. These documents have already been checked and the hard copy annotated appropriately by the GP. Invoke the scanner from Correspondence..Actioned Items from the front screen. From here you can allocate the documents to the appropriate patients, and store in their records.
- 3) **Checked Documents —Single Patient**. Either, Invoke the scanner from *Correspondence..Actioned Items* from the front screen, or directly from within the patient record from any of the *Documents/Results/Letters/Correspondence* tabs.

When you first press the *Scan* button, you will presented with the dialogue screen from your installed scanner software. At this point you select your scanning parameters, bearing in mind that the higher quality settings you choose, the more space your scan takes up in the MD document database. Over time this can make a significant difference to your system performance. **Generally, you should be using the lowest quality settings that result in a clear and fully legible scanned document.**

Once your document has finished scanning you will be presented with the following screen, (illustration shows sample document)



The left side of the screen gives a thumbnail view of the page(s) to facilitate easy navigation of the document. The right side of the screen gives you an editable preview of the selected page.

The *Annotate* menu along with equivalent icons, give the GP certain tools for highlighting or emphasising part of the document as per the above illustration. There is also the ability to type a comment and place it on the document.

The *Cleanup* menu has some tools for tidying up the appearance of the document, e.g. removing speckles or straightening the page.

Once the document is ready to store, or forward to the *Holding File*, select *File*...*Close and Save*, or click the save icon.

Scanning

Scanning Workflow Choices

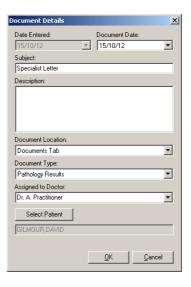
The final stage in the process is the *Document Details* screen, where depending on which scanning workflow you are following, you can complete any missing information as per the illustration below.

NB

Document Location—This is the first opportunity you get to specify the end-storage location for the document in the patient record. This location can be changed at any stage of the document journey.

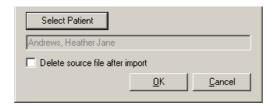
Assigned to Doctor—If this document is destined for the GP *Holding File*, the selection here determines which GPs correspondence the document appears in. If the document has already been checked, then this selection is for recording/documentation purposes.

Select Patient— This selection determines which patient record the document will be stored with, either immediately or after the document is checked by the GP via the *Holding File*.



Importing Documents

The choices and rules for importing are almost identical to those for scanning, detailed at the top of page 10. The *Import* button is located next to the *Scan* button on all of the applicable screens. You have the option of importing multiple documents at once or one document at a time. When you press the *Import* button, you are given the facility to browse to where you have the electronic documents, (e.g. pdf or doc files) stored. Once you have selected the file, you will be presented with the *Document Details* screen, which is the same as the one you see after scanning, with the exception that there is an option to delete the original source document, as per below.



NB If you have opted to import multiple documents in one go, you will have to manually invoke the *Document Details* screen for each document by clicking the appropriate button at the immediate left of the scan button.

The Patient Record

Sections

The patient record has a total of 4 tabbed sections for displaying electronic documents:

Results - Usually shows pathology/radiology reports

Documents - Usually used for Specialist letters/reports and discharge summaries etc

Letters - Documents generated by the practice and sent to external parties or the patient

Correspondence - A combined view of all the items displayed on the previous three tabs.

NB You can supress the display of the *Correspondence tab*, or all 3 of the other tabs, by making the appropriate selection from *Tools..Options..Clinical*, from the MD front screen.

Controls

All 4 of the electronic document related tabs, contain almost the same display and action buttons that are available in the Correspondence related screens outside the patient record. To recap:

Top Buttons. From here you can:

- Control the location of the *Preview* window, Bottom, Right or off altogether.
- · Toggle between full and partial preview
- Clear all filtering selections you have made from the Column Headings
- Move the storage location of the item between results/documents etc
- Edit the Document Details of a scanned or Imported Document
- Do a text search of all the documents
- Scan/Import/Delete a document

Column Headings. Lots of ways to fine-tune the display of documents including:

- Using the downward arrows you can narrow down or filter the displayed documents
- · Clicking on the column headings will sort the displayed documents
- By clicking and dragging, you can change the order the columns order.
- By clicking and dragging on the Column Heading edges you can resize the columns.

Bottom Buttons. These are only visible if you have the preview window enabled, and set wide enough to reveal all the buttons. From here you can:

- Mark a result as notified
- Assign the item to another Patient
- Edit a required follow-up action
- Add a Recall
- Print the item or view the Audit History

NB The ability to move the storage location of a document, gives the user the ability to retrospectively optimise document storage in ways that were unavailable prior to MD 3.14