PracSavvy

Clinical Systems Support and Training

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December 2021 — Newsbrief

Welcome to the last newsletter for 2021, and I imagine a collective holding of the breath as we all wait to see exactly what will happen after December 15th. My money's on December 16th, but these days you really can't be sure of anything.

I wrote in the last newsletter around the fact that sometimes we do things by rote, without really thinking too hard. I wonder if that sometimes applies to what we say as well. I'm not talking about my least favourite sentence of all time, namely, "It was/was not meant to be", but rather the one that goes, 'we have a really old patient demographic, so that wouldn't work for us'. We may have to think about our definition of old, but it's our definition of technology that I'm getting at here.

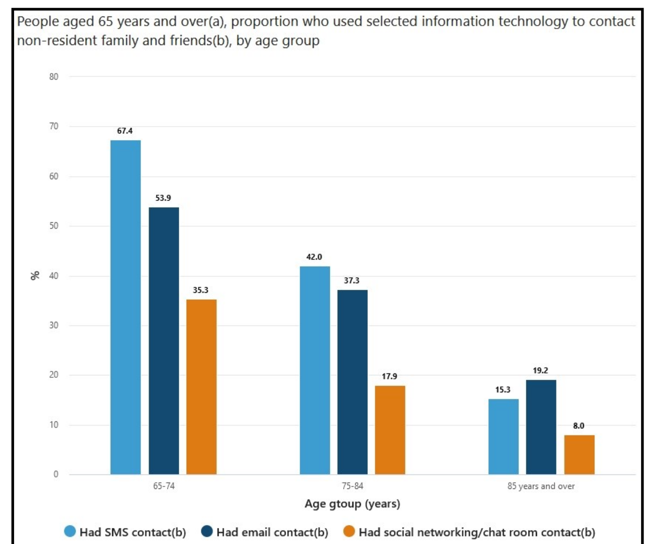
I think there is a case for not including SMS in the category of technology that is out of reach for at least some of our elderly. I'd contend that SMS is getting close to being as demographic wide mainstream as calls on a landline used to be. You can get mobile phones designed with seniors in mind, but more to the point, sms messaging started to be used regularly in Australia around 2001. Twenty years have elapsed since then, which should remind us all that today's 70 year olds were a sprightly 50 when texting started to become common. Of course these devices have evolved and become the favoured tool of the anatomical *over-sharers*, but that's another story…

On a series note though, consider the graph below gleaned from 2018 ABS data

For those reading a printed black and white version of this newsletter, the tallest columns in the 3 age ranges reflect SMS usage and the smallest ones reflect social media/chat room contact.

I've always thought SMS reminders were a far more robust and low maintenance method of contact, as opposed to relying on a patient having an app on their phone and keeping it updated and installed.

See that even in the 75-84 group, 42% of the respondents had used sms for contact purposes.



Unfortunately I couldn't find anything of a non-marketing nature that was more recent than 2018, but I would expect these numbers to be a little bigger now given the passage of time, and possibly quite a bit higher given the stimulus of various lockdowns and isolation situations caused by the pandemic. (Speaking of pandemic, see here for how to display your vaccine certificate in the *Check-In Tas* app)

So it may be time to revisit our preconceptions around age ranges and sms messaging.

Templates

The following new or updated templates are available at my website here:

- 3rd dose pfizer eligibility form
- Cardiology Tasmania Ref (at their site)
- All about Wounds (updated) *
- THS South MRI Request (updated) (*MD users set 5mm margins*)

* *All About Wounds are no longer working from Mountain Retreat clinic but are providing in-home and nursing home consultations at no extra cost, within 15km of Hobart CBD.*

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eReferral

Please note the following ereferral (Healthlink EDI) changes. As always the full listing can be found on my website here.

♦ Dr Imogen Innett	Neurosugery	Neurosurgery Tas Tasmanian Spine Service	*neurotas* *tasspine*
♦ Dr David Humphries	Sports Medicine	The Sports Medicine Practice	*spmedprc*
♦ Dr Stephen Reid	Sports Medicine	The Sports Medicine Practice	*spmedprc*
♦ Dr Liam Geraghty	Sports Medicine	The Sports Medicine Practice	*spmedprc*
♦ Lea Young	All about Wounds	Mountain Retreat *cascderd*	Delete

BP

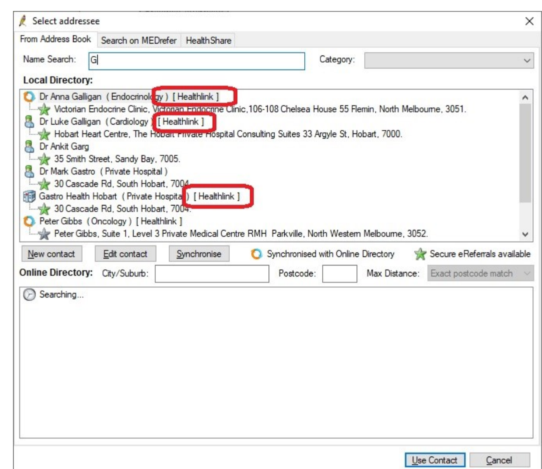
If you upgraded to Saffron SP2 over the last month, you may have encountered a couple of bugs, principally an issue where an emailed pdf could not be printed and also an error where the date selections on the subpoena tool were not generating the correct content. BP rectified this in the last week in November with a Revision 1 version of SP2 which you can read about here.

If you installed the original SP2, you may want to install this. If you hadn't installed SP2 and want to now, this is the version to install, but **make sure to read the notes on your Proda configuration first**. This detail was missed by plenty of people around the country and resulted in an inability to perform online patient verification after the upgrade. Bottom line is get on top of your Proda setup, register your organisation and have at least one user account linked with appropriate permissions going forward

eReferral

I feel like I see a few practices with ereferrals returning an error message on the View..eReferrals status screen accessible from the front screen in BP. The majority cause of these errors is documents being directed at parties that do not have a healthlink address. It's an annoying issue that if you try to send to a recipient that isn't healthlink enabled, the program does not stop you when you click the send icon. Rather you get a confirmation message that the document has been dropped into a Healthlink "out" folder. It is only when Healthlink tries to send the document and there is no Healthlink EDI in the header that an error is then generated and reported on the status screen.

All this causes extra work for practice admin and delays the actual referral process. So, can I urge GPs when they are selecting the document recipient to watch for the word *healthlink* after the name of the intended recipient. This is the only way to be certain that the person is configured for Healthlink in your *Contacts* (address book)



In the past we have spoken about the colour of the star, but the functionality around that has changed in the last couple of years. Again, the word Healthlink after the recipient name is you cue for ereferral.

I would also repeat my recommendation that admin staff monitor the *View..ereferral* screen and also encourage you to be fastidious about maintaining the *Contacts (*address book*).* Note also that spelling a Healthlink EDI incorrectly will generate a failed referral. As always, my listing can be found here, and I'm always happy to hear if there is anyone that I am not aware of that should be listed.

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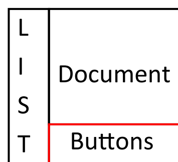
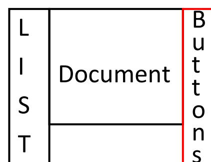
BP

A couple of preference settings that GPs may really like are depicted below and refer to the In-Box screen.

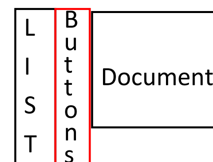
The result status and follow-up action buttons in the In-Box are by default shown under the document view window. Using the left most setting you can make those show vertically at the far right of screen, but I think the real bonus is being able to display them at the left, adjacent to the document list. In this way you can potentially work fluently from left to right and easily see which documents that you have actioned prior to closing. Something like this



Default



First Option



Second Option

MD

Vaccines somehow not finding their way to AIR seems to be the problem that keeps on giving, especially for MD users.

Whilst I've stated that the best thing you can do is eyeball the *Send to AIR* checkbox as the very last thing you do before you click *Save,* there is another behaviour you can adopt that will eliminate a lot of the non-uploaded situations that occur.

Full credit to Alison from Eastern Shore Drs for really getting to the bottom of this. The key behaviour is to **always** select the vaccine from the drop-down list. If you start to type the vaccination and it autocompletes , **do not** just hit enter as the AIR checkbox will not be enabled. Always click on the list item as is depicted in the graphic.

This remains a really poor bug in the software and hasn't been rectified as at release 4.1

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Duplicate Patients

Given that there is obvious clinical risk with having duplicate patient records in your system, it is a reasonable QI exercise to check for their existence on a regular basis.

In MD you can generate a list by selecting *IHI Exception report* from the *Patient* menu on the main screen in MD. This report shows you patients who have the same IHI number recorded. They will most likely be straight duplicate records, but check carefully in case there is another type of error.

In BP from the front screen, select *Utilities..Search*, then click the *load query* button, browse to the *Supplied queries\Demographic* folder, double-click *Duplicate patients by name, dob.sql* and then click *Run Query*. If that sounds too complicated just copy the text below into your query window (replacing what's there) and click *Run Query*.

```
SELECT *
FROM BPS_Patients
inner join BPS_Patients as B1 on not b1.internalid = BPS_Patients.internalid
 and BPS_Patients.dob = b1.dob
 and BPS_Patients.surname = b1.surname
 and BPS_Patients.firstname = b1.firstname
WHERE BPS_Patients.StatusText = 'Active' and b1.statustext = 'Active'
ORDER BY BPS_Patients.surname, BPS_Patients.firstname
```

It's come to my attention that at least some of these duplicates are caused by a third-party booking program. I'm unsure of the exact circumstances this happens under, but if you use BP and check the bottom left corner of the patient's demographic information, the culprit may be named.

If you do have duplicates and there is clinical information is in both records, then merging the records is probably required. There are instructions here for MD and BP. I would strongly recommend taking great care here and doing it when you are not going to be uninterrupted as un-merging records is to be avoided and can be problematic.

Hepatitis C Virus (HCV) scripts

Very happy that Assoc professor Louise Owen from the Sexual Health Service has sent me some prompt scripts for HCV pre-treatment that can be added to GP software. Simply click on *Add to List* under the *Comment* button (MD), or *Add* under the *Autofill* button (BP), and copy and paste either or both of the protocols below, remembering to add a suitable shortcut.

1 HCV Pre-Treatment discussion - IAW GESA guidelines

Detailed discussion about the pros and cons and pot S.e of DAA meds with likely timing of 8-12 weeks course with 97% SVR response;
Discussed workup that would be required, & on treatment compliance.
Check DDI
Contraception if required;
Reflexive Testing include LFT's + AST for APRI. If Apri >1.0 then order radiology/elastography.
BBV serology and vaccination
Examination
Consent to inform GP- yes/no
Follow up 12 wks after End of Treatment for SVR. PCR-RNA & LFT's, f/up require linkage with GP.

2 HCV pretreatment- -Checklist-

APRI checked if >1.0 then imaing+elastography to rule out cirrhosis. (ref to gastro if cirrhosis)
HIV and Hep B status checked;
HBV vaccination-
Side effects and potential ADE discussed
-Check DDI/ adjust current medication if required-
Check Contraception if relevant
Pt agreed to report any ADE earlier if noticed;
Monitoring-Check compliance can do
SMS at 2 weeks to check progress;
Nil on tx monitoring required.
Rebook for 12 weeks post end of treatment for face to face visit & test, LFTS HCV-PCR.
Duration of treatment- 8 or 12 wks."

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