

PracSavvy

Clinical Systems Support and Training

www.pracsavvy.com.au

Edition 82 - June 2023

Welcome to the newsletter, where this month it's a veritable referral extravaganza! The major development of course is the addition of some 40 odd RHH clinics to the choices available under Healthlink Smartforms in your clinical software. I won't lazily use up newsletter space by listing them all (like I did previously!), but you can find the specifics [here](#) if you like. This doesn't seem to be the end of the goodies either, with PHT advising that there will be further additions in July including some THS Community Services.

Furthermore we have the great news that the Bone Densitometry Clinic at the Menzies Institute are happy, if not downright keen to receive your referral requests via their Healthlink EDI at *utasmenz*. If that wasn't enough e-joy, please be advised that Diabetes Australia Tasmania have a new Healthlink EDI for referral use, that being *diabeaus*.

Check page two for a little more important referral information and some address book updates.

On another note, practice managers may well want to add this excellent [collection of MBS/Medicare resources](#) to their internet favourites.

I'm generally not a listener to non-health technology related podcasts but I found this one with the really appealing tagline of "[Culture eats strategy for Breakfast](#)", and that got me in. My favourite part was that being as it was a podcast there were no markers or butcher's paper and whilst I think the idea of making a workplace "fun" only really works for toddlers, I absolutely do appreciate the benefits to patients and staff of creating an environment that people feel personally invested in.

It's human nature to want to feel part of something that's bigger than you, hence religion, sports clubs, rock concerts etc. It's also uplifting to think that if you are going to work long and sometimes stressful hours, it sure helps if you feel like your organisation is doing some good in the world. By "doing some good", I don't mean saving the planet by riding a bicycle either. I mean actual contributing to the wellbeing or success of your community type activity.

Culture starts at the top, and this has to be, whilst not impossible, much harder in the increasingly corporate nature of General Practice. It's not that a corporate acquired practice loses its *personality* overnight, but I'm sure there is a connection between allowed autonomy and personal investment for the leaders at a practice. Practices absolutely need discernible onsite leadership, to enforce adherence to standards and quality systems as well as foster and encourage the human qualities that can lift the practice to greater heights for staff and patients alike.

You see it (positive culture) in practices when staff make unsolicited comments praising their colleagues. You see it, as I have when people confess that their very outlook has changed after working for a certain organisation. You see the lack of it when practices have a high turn-over of junior staff, especially nurses. You see the lack of it when clinicians show flippancy for helping maintain the practice logistical processes that result in extra work for their colleagues when done badly. I mean it's one thing not to do it, it's another again to think that creating unnecessary work for others is funny.

I've seen practices where there seems to be zero onsite leadership, where inexperienced staff are left to flounder. Everybody retreats to their room and possibly great things happen behind the closed door, but outside the place is clearly fragmented and there is essentially no shared vision or focus. In this environment often the only factor in retaining staff is the hourly rate of their pay. The other thing to be said about good culture is that it's not achieved by one-off social activities, although these can certainly help. What really counts with people is how they are treated and respected on a day to day, 9-5 basis.

Also worth mentioning the culture that a new GP walks into to. I saw a facebook post on a national practice management group. It read something like, "we've got a new GP starting today and she's never used Best Practice. Does anybody have one of those BP mouse mats?" WTAF! They will probably put the Strengthening GP Grant Money towards some new mouse mats.

To conclude my workplace cultural ramblings, I have thought for quite a while that the best organisations often have a *visionary* and a *pragmatist* in the top two positions. (airy-fairy type and bean counter if you prefer pejorative descriptors). Importantly the two people have to like or at least respect each other.

...Continued over

PracSavvy

Clinical Systems Support and Training

www.pracsavvy.com.au

Continued..

I saw a nice analogy about this the other day with the situation likened to a kite on a string. The kite is the visionary, but without the string it will be blown off into the ether, totally out of control and crashing into a tree somewhere. The pragmatic string however, without the kite is just a limp bit of string lying on the ground, providing nothing for anybody. Together though, great things can happen.

E-referral

Please see below for some e-referral updates for your address books. My listing of e-referral enabled specialists and Allied Health providers can be found [here](#):

Dr Graeme Jones	Bone Densitometry	<i>utasmenz</i>	Menzies Centre - Hobart	
Diabetes Australia - Tasmania		<i>diabeaus</i>		
Dr Sarah Thomas	Anaesthetics	<i>chctlvcs</i>	Calvary Consulting Suites	
Dr Roya Shahidi	Haematology	<i>chctlvcs</i>	St John's Sessional Suites	
Dr Sana Atif	Rehabilitation Medicine	<i>chctlvcs</i>	St John's Sessional Suites	
Dr Prudence Smith	Haematology	<i>chctlvcs</i>	St John's Sessional Suites	
Dr Helen Castley	Neurology	<i>chctlvcs</i>	St John's Sessional Suites	Delete
Dr Troy Cowell	Occ & Environ Med	<i>hobocmed</i>	Hobart Occupational Med	Delete
Dr Umair Hayat	Cardiology	<i>lmc32lmc</i>	Launceston MC	Delete

There are three things that need to be mentioned in terms of the THS smartform e-referrals:

1) Practice staff please keep an eye on the status of referrals via *View..Healthlink Forms* in BP and *Tools..Healthlink..Track Forms* in MD. There won't be any incorrect addresses but you may see some forms that have been saved but not sent. *Completed* is the document status you are looking for.

2) In Best Practice especially the *Submitted* document does not always display immediately in the outgoing correspondence. Sometimes using Ctrl-F5 to refresh the display reveals the form, other times it is only displayed after exiting and re-entering the patient record. But it is there, so there is no need at all to print the referral and scan it back in.

3) If you are using BP and IF you have not updated to the Orchid release and IF you have GPs set up as *Registrar* or *Contract Doctor* there may well be issues with completed forms being sent correctly. The solution is to change their user type in BP to *Contract Doctor* or *Principal Doctor*, or better still update to the Orchid release which has been available for over four months now.

There are instructional documents available at the dedicated Primary Health webpage [here](#), as well as a list of upcoming enhancements. Don't hesitate to let them know if you think there are any issues with these smartforms.

Templates

Templates updated or created last month at my website [here](#):

Wellways to Recovery Referral
Specialty Imaging Request (North)

E-scripts

Some late breaking news here, as I hear that sms e-scripts are going to continue to be funded until the end of September. After this time the funding model will change. The greater import of this will be that [Medisecure](#) will no longer be an option as a **FREE** e-script provider after September 30th. This will be a huge shame as the national consensus from tech types around the country is that it is a far more stable product with a far more responsive support team.

I expect that you will see some simplified information from your clinical software providers over the next week or so. In the interim there is some reasonable information [here](#) and some legal machinations [here](#).

Edit: This was updated after the original newsletter email. Enquiries email is: eptransition@health.gov.au

PracSavvy

Clinical Systems Support and Training

www.pracsavvy.com.au

Primary Sense

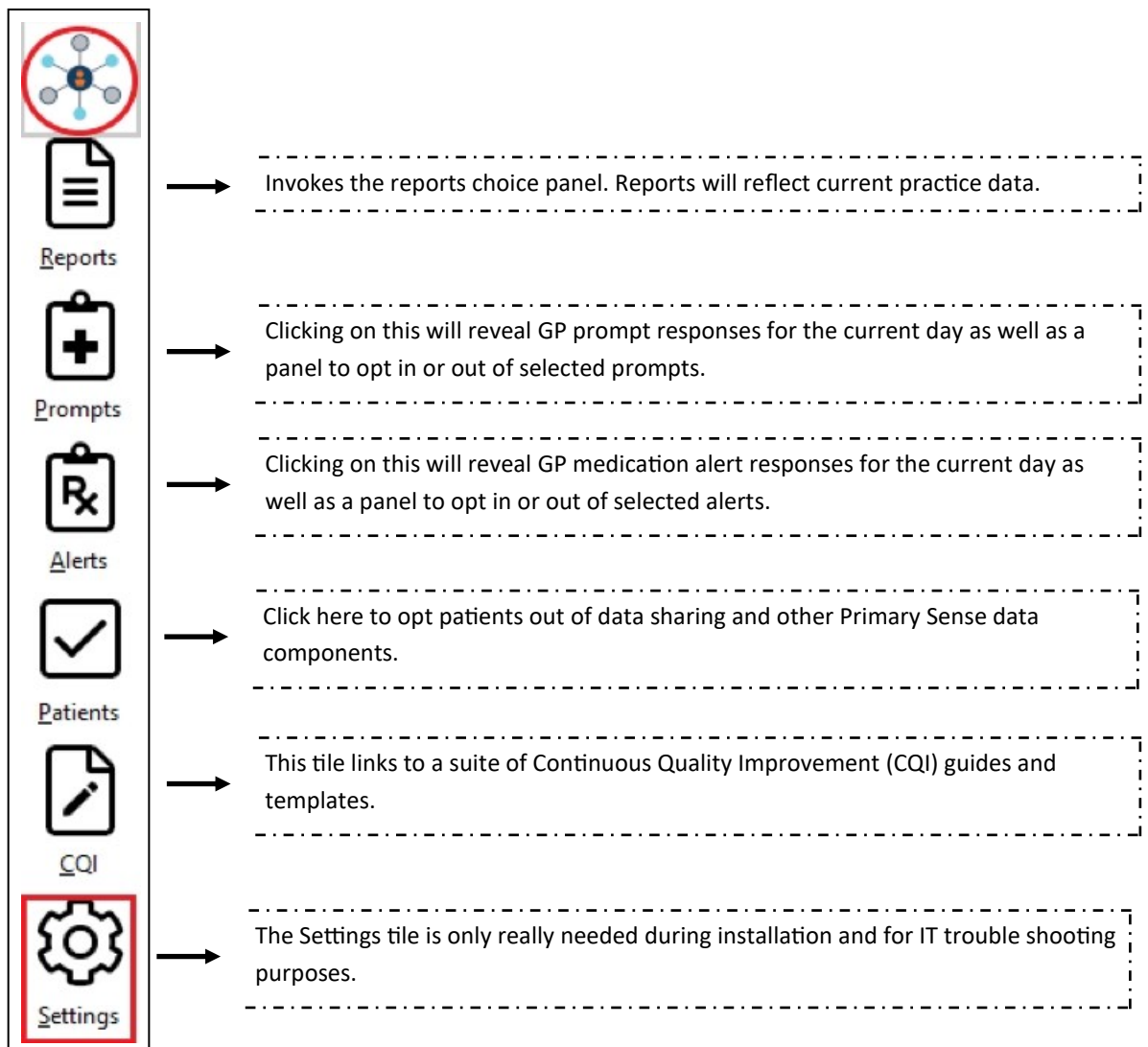


In a typically hard hitting review in the [February edition](#), I wrote a bit of an opinion piece on what I liked and didn't like about the Primary Sense tool. This article was based on what I was able to glean from the publicly available learning resources. [Primary Sense](#) of course is the replacement for the PenCat tool that practices have been using to facilitate data sharing with the PHN. It will be used for data sharing from July and it is my understanding that it is being rolled out as we speak.

I feel like it's now time to write a more detailed article on the program, although ideally people may want to read/re-read the February article in conjunction with this one as they will complement each other. Particularly the "what I like" part of the February piece. In the interests of transparency I must concede that I have no access to the program and at the time of writing have never used it in a practice. I have however viewed the videos and read the documents [here](#) and [here](#) at least 2 to 3 times, and well, I'm me! 😊

Primary Sense is a real time data extraction tool that updates every 10 minutes or so. The main components of the program are information reports, medicine alerts and GP Prompts. The last 2 components are only available to GPs, which is why your practice may have Primary Sense installed on every GP desktop.

You invoke the Primary Sense tile bar by clicking on the icon on your desktop or taskbar.



Note that if the top three tiles are orange it means that no data has been collected by Primary Sense for over 24 hours. Similarly, if the top three tiles are red it means that the program has stopped working and a call to IT is required.

PracSavvy

Clinical Systems Support and Training

www.pracsavvy.com.au

Primary
Sense



Reports

Clicking this tile reveals the reports panel as below.



Primary Sense™ Reports

GPs - Important clinical information about your patients are in most of these reports.

Select a report

Patient Lists

- Benzodiazepine in substance misuse
High risk patients
- COVID-19 Vulnerable Patients
Vaccination eligibility and status
- Pregnant and Vaccinations
Due influenza and/or pertussis
- Haemochromatosis
Associated risk indicators
- Diabetes Mellitus
Diagnosed and undiagnosed
- Health Assessments
Eligible or due
- Patients with High Complexity (5 and 4)
Eligible or due care planning items
- Bowel and Breast Cancer Screening
Patients eligible
- Chronic Lung Disease and Asthma
Associated modifiable risk factors
- Cardiovascular Disease Risk Factors
Modifiable risk factors
- Frailty Care Management
Patients with Frailty risk factors
- Patients with Moderate Complexity (band 3)
Eligible or due care planning items

Practice/PHN Reports

- Characteristics of the Practice Patient Population
For comparison to the PHN version
- Accreditation
% compliance
- Summary Report of Practice Improvements
Monitors changes
- Your Practice Data Quality
Compared to PHN average

PIP QI

- PIP QI report - 10 measures
% compliance
- Patients missing PIP QI or accreditation Measures
All patients missing measures
- Patients booked in with missing PIP QI measures
With appointments in the next 2 weeks

Primary Sense Information

- What's New & FAQ
Keep up to date
- Troubleshooting Guide
Technical options and support

Keyword filter: Clear

- Alcohol
- Allergy
- Anti-Hypertensives
- Benzodiazepine
- Blood Pressure
- BMI
- Cancer
- Care Plan
- Cervical
- Chest Infection
- Cholesterol
- Chronic Disease Risk
- Coded Conditions
- Complexity Bands
- COPD
- COVID-19
- CV Risk
- Data Quality
- Diabetes
- Ethnicity
- FAQ
- Fasting Glucose

These are the reports available. Hopefully with future development there will be more to select from. Note that the Practice/PHN reports return some standard benchmarks but do not link to patient names.

Users will be unfamiliar with the content of these reports to start with, which makes the keyword filter panel on the right hand side a handy feature. Select the topic you are interested in and the report selections will be filtered accordingly.

As mentioned previously, data is refreshed every 10 minutes or so, so information should be right up to date. Any reports generated will open in your web browser, with a copy automatically saved to a reports directory under the users local documents directory. This is important because it represents the only way you can "look back" at historical snapshots within the tool to show quality improvement. There is no previous extracts area as with Cat4. So if you choose a quality improvement target and want to compare today's numbers with 12 months ago, you better have run the identical report 12 months ago. All fine if you had, or even if you had saved a spreadsheet version of the report outside the tool 12 months ago.

So you lose the ability to randomly look back to a point in time and compare with today's situation. This information will only exist if you ran the report on those numbers at that time. For that reason I believe saving any generated reports to the users MyDocs area is a fundamental error as only that user can retrieve these reports going forward, (if they still work at the practice!). **This should be a configurable item pointing to a shared folder on the server so that any generated reports are saved here and available for anybody's access.** This is what currently happens with the CAT4 extracts folder when the program is installed optimally. In the absence of this setting, I would be creating a shared folder on the server and copying the generated reports here manually, or at least the ones you feel you may want to keep.

The top section of all reports have a fairly standard look as depicted over the page.

PracSavvy

Clinical Systems Support and Training

www.pracsavvy.com.au

Primary Sense



Reports

DEMO
22 March 2023 13:44

Which patients are included in this report? What data is in this report? How do we use this report? What are ACG patient complexity levels?

Patients with Frailty indicators

Information about this table

N indicates no blank means no results found

Show 25 patients per page

Export To Excel Export To CSV

Search

Remove	ACG Score	Patient Name	Patient Phone	Last Visit	Existing Appt	GP Name	Clinic	Age	Hospital Risk %	Chronic Conditions	ATSI	Lives Alone	Frailty Indicator	Sedatives History	Chest Infection History	Flu History	History Of Fluorax	Frailty Flag
Remove	5	Johnson, R	0401 234 567	2022-09-24	Nil	Dr V Martin	Surgery	66		11	N	N	Weight loss	N	URTI, URTI viral		2022-09-05	N
Remove	3	Nguyen, A	0401 234 567	2022-07-24	Nil	Dr V Martin	Surgery	78		6	N	Y		N			Nil	Y

Primary Sense (PS) gives you pretty much no choice with report parameters, they choose them for you. This is where the Teals are super useful, (unlike in the political sphere). The teal buttons give you very specific information about the patient group that was selected in the report as well as other data sourced and potential usage for the report. **If I was running a PS report these boxes would be the first thing I would check, particularly the “Which patients” one.**

For example in PenCat, the default patients selected are everyone that is not marked as inactive or deceased in the database, modified by what other parameters you choose to apply. In the case of PS, apart from subject specific configuration the patient group is usually one of three:

- 1) Patients who are marked as Active in your database
- 2) Patients who are RACGP Active (3+ visits in the last 2 years)
- 3) Patients who have had a visit or a script in the last 12 months

It’s not clear to me yet, the rationale for which of the three choices that are used in each report, apart from the QPIP and Accreditation ones which quite rightly select patients who are RACGP Active. Again, click on the teal boxes so you can fully understand the report you are looking at.

You can click on any of the column headings to sort by that column which is certainly handy because of the use of clinical complexity and hospitalisation risk ratings and also the next appointment field. Note that this particular report has a *Clinic* field. I don’t know that the other reports have this, which is a real shame because **it’s pretty much the only way the multi-location practice can run location specific reports.**

The Search field shown at right of screen is handier than you might think, because it’s essentially **the only way you can further filter the data within the PS program.** For example if you put Dr Smith in the search box, the report would only display patients who see Dr Smith. So you have one level of filtering available to go along with the ability to sort on any column. If you want to filter further (and you will!) then this will have to be done by exporting the report to Excel or CSV format where you can take advantage of spreadsheet tools to further refine your selections.

As I mentioned in February there’s some data in these reports that I really like:

1) John’s Hopkins Adjusted Clinical Group (ACG) rating. - Many of the reports you can call up from your extracted data have a column that allocates the patient an ACG level of complexity rating between 0 and 5. These risk bands which are allocated as part of the extract process, are internationally recognised and used in many countries around the world.

2) Likelihood of hospitalisation in the next 12 months. - For people in ACG band 4 or 5 there is an algorithm that calculates the likelihood of hospitalisation in the next 12 months. If this number is calculated to be over 80%, it too appears on many of the patient reports.

3) Chronic Disease and Diabetes risk ratings. For people aged 40-49 a risk factor for Chronic Disease (0-6) and a Diabetes Risk Score (2-19) are also generated. In a similar but less dramatic vein to the first 2 points, these ratings may help ensure that the right patients are focussed on.

4) Existing appointments. Primary Sense does have some data quality and MBS Item potential reports, and a handy feature of these show the date of any booked appointment for the patients shown on the list. A column showing the date of the last visit of the patient is also useful.

PracSavvy

Clinical Systems Support and Training

www.pracsavvy.com.au

Primary Sense



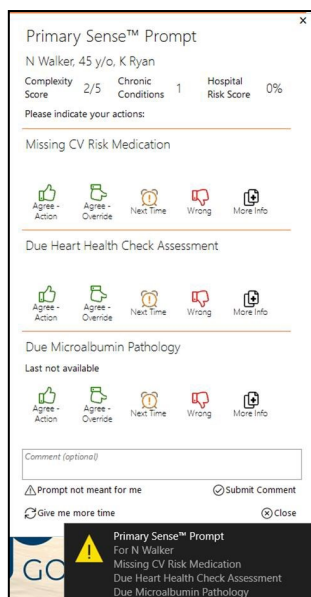
Prompts



Another feature of PS that applies to GPs only are clinical prompts that display when a patient record is opened and certain issues are noticed. Currently the issues that generate a prompt are:

- Due influenza vaccination
- Due pertussis vaccination
- Due Meningococcal vaccination
- Due Hepatitis A Vaccination
- Consider Haemochromatosis testing
- Missing CV Risk Medication
- Due Heart Health Check Assessment
- Due Microalbumin Pathology
- Due Care Plan
- Due Mental health care plan
- Due Medication Review
- Due ATSI Health Assessment

If a patient triggers multiple prompts the most important three will be shown on the initial tab which displays for three minutes. If there are more than three applicable prompts, actioning one will result in the fourth one being displayed and so on. This is an example prompt screen.

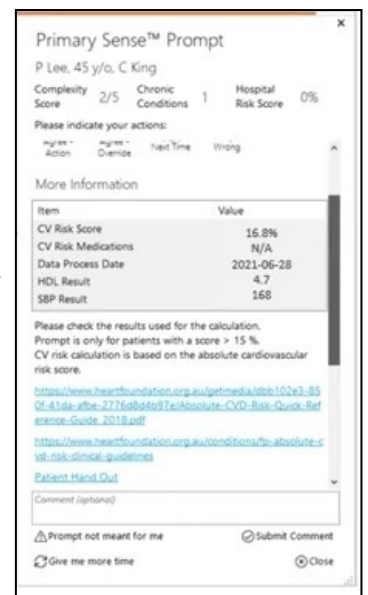


The top bar of the relevant prompts show the patient's AGC complexity score, the number of chronic diseases and their risk of hospitalisation if over 12 months.

The middle section shows the relevant prompts. The *More Info* icon shows you the information which triggered the prompt, often with links to clinical references.

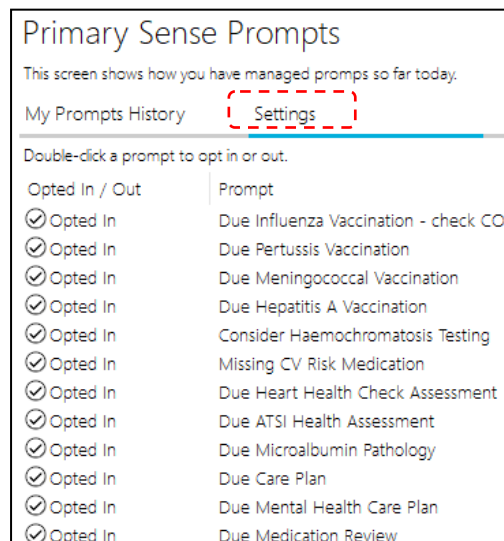
The *Next Time* icon removes the prompt until next time a Doctor sees the patient. Selecting any of the other three options will result in the prompt not displaying for the patient again for a full 12 months.

The bottom area gives an option to close the entire prompt dialogue for this patient while the Give me more time icon will result in the prompts being displayed for another 3 min.



As mentioned earlier, clicking on the prompts tile in the main PS tile bar will generate a prompts history for the current days consultation, showing what actions were taken by the GP.

The second section shows the currently available prompts and whether the GP has opted out of any of the prompts. Opting in or out is done by double-clicking on the desired item.



PracSavvy

Clinical Systems Support and Training

www.pracsavvy.com.au

Primary
Sense



Alerts

Another GP specific component of PS is the medication alerts. This is the current list.



My Alerts History **Settings**

Double-click an alert to opt in or out.

Opted In / Out	Alert
<input checked="" type="checkbox"/> Opted In	Prescribing Azothioprine/Mercaptopurine without thiopurine methyltransferase testing (TPMT)
<input checked="" type="checkbox"/> Opted In	Prescription Metformin where latest eGFR \leq 30ml/min
<input checked="" type="checkbox"/> Opted In	Prescribing biological medication without lab tests within the last 6 months
<input checked="" type="checkbox"/> Opted In	Prescribing Immunosuppressive drugs without lab tests within the last 6 months
<input checked="" type="checkbox"/> Opted In	Prescribing an anti-platelet drug where there is a history of peptic ulcer or gastrointestinal bleed and no gastroprotection
<input checked="" type="checkbox"/> Opted In	Prescribing antipsychotic medication without lab test within the last 12 months
<input checked="" type="checkbox"/> Opted In	Prescribing a combined hormonal contraceptive where there is a history of migraine
<input checked="" type="checkbox"/> Opted In	Prescription of hypoglycaemics other than simple metformin in elderly patients (age \geq 75) with Hba1c \leq 7.0(53mmol/mol)
<input checked="" type="checkbox"/> Opted In	Prescription of fentanyl patch in non-cancer pain
<input checked="" type="checkbox"/> Opted In	Prescription of digoxin where latest eGFR \leq 45 ml/min
<input checked="" type="checkbox"/> Opted In	Prescribing a bisphosphonate medication for Osteoporosis where latest eGFR \leq 35 ml/min
<input checked="" type="checkbox"/> Opted In	Prescription of hypoglycaemics other than simple metformin in patients (age \geq 75) with Hba1c \leq 6.5 (48mmol/mol)

In this instance and to save some space, I'm showing the list of prompts as are shown if you click on the Medication Alerts tile from the main PS tile bar. Exactly like the convention for clinical alerts this screen initially shows the GP responses to today's alerts as well as a listing for opting in and out of the alerts via double-clicking.

In the patient record PS is apparently checking every two seconds for a prescription that will trigger one of its alerts. If an alert is generated it will look like this.

Primary Sense™ Medication Alert

Avrom Smithies
METFORMIN

This medication alert has been generated because of metformin prescription in the presence of renal impairment at eGFR < 30 mL/minute.

Although generally not recommended when eGFR < 30 mL/minute, metformin may be considered for patients with stable renal function and eGFR > 15 mL/minute, with careful monitoring.

With eGFR 15–30 mL/minute a maximum metformin dose of 500 mg daily and check renal function **every 4–6 months**.

Stop metformin if patient becomes acutely unwell and is at risk of further deterioration of renal function (and counsel patient accordingly).

Comment (optional)

Appropriate – I will take action Appropriate – but I want to override

Inappropriate - wrong for this patient Remind me again when I repeat this prescription

1/01/2017 1/04/2017 1/07/2017 1/10/2017 1/01/2018 1/04/2018 1/07/2018

As you see the alert gives full detail of its rationale, you may even have to use the scroll bars to read all the information.

There are no colourful icons to click here, with the response choices being highlighted to the left. Note that selecting anything other than the “Remind me again..” option will result in the alert being suppressed for a full 12 months for this patient.

The authors of PS claim that these alerts do not duplicate existing clinical software medication alerts. If you find they do, I would encourage feedback of this to Primary Health Tasmania.

So there it is, a nice five page guide from a guy who has never used the program. What could go wrong? Apologies for the quality of some of the graphics as they were sourced from other peoples documents and videos, doubtlessly violating copywrite somewhere along the line.

Quite apart from comparisons with CAT4, I'm really interested to see if the program delivers on what it actually claims to do, especially in the areas of speed and stability that are implied by a “real time” description. I certainly hope so, but we shall see.